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THE CAROLINA
JOURNAL of PHARMACY

JAN-FEB 1982 VOLUME 62 NUMBER 1-2

THE HECKMAN BINDERY, INC. N. MANCHESTER, INDIANA

102nd Annual Convention

North Carolina Pharmaceutical Association
and
Affiliated Auxiliaries
The Woman's Auxiliary
The Traveling Member's Auxiliary

THE HYATT WINSTON-SALEM
WINSTON-SALEM, N. C.
APRIL 4, 5, & 6, 1982

CONVENTION ISSUE

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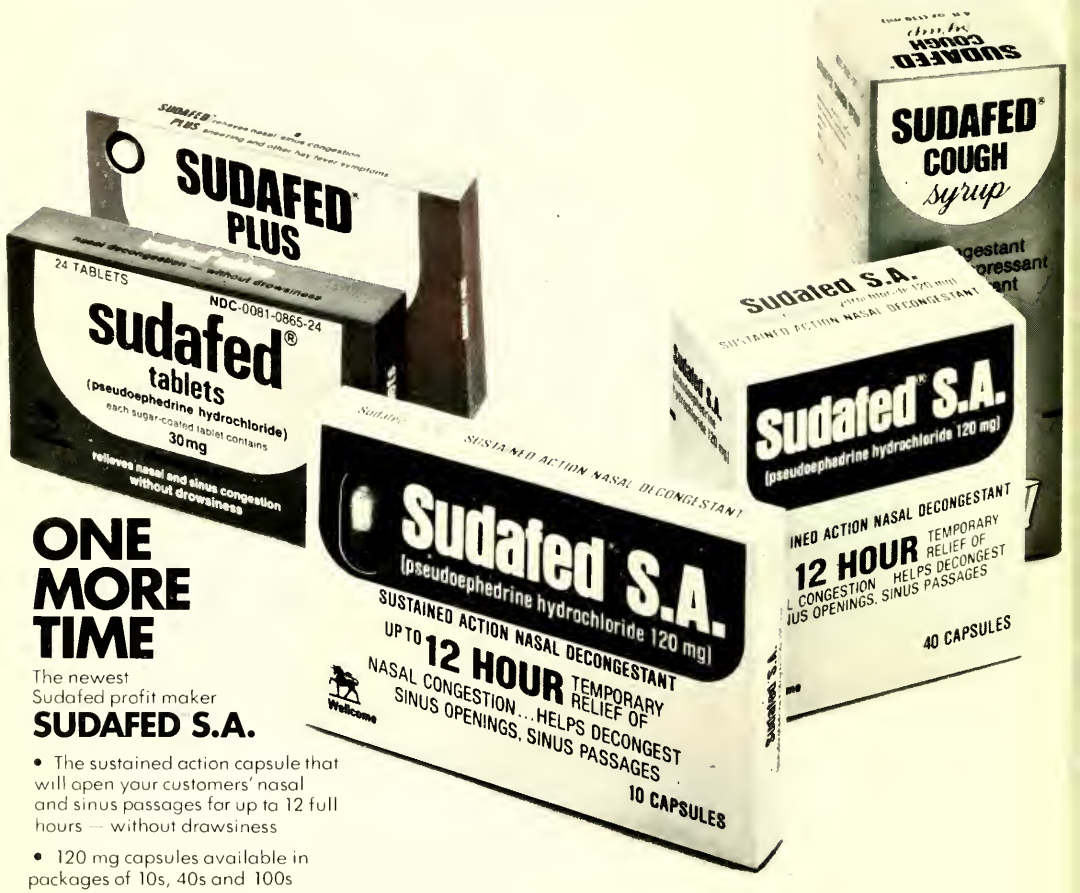

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CONVENTION INVITATION

Looking Forward to Meeting and Greeting Our

Many Friends at the

102nd

Annual Convention of the NCPhA

55th

Annual Convention of the Woman's Auxiliary

of the NCPhA

68th

Annual Convention of the T.M.A. of the NCPhA

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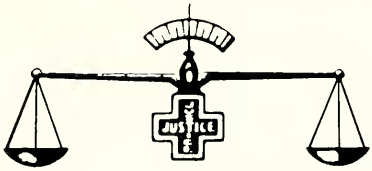

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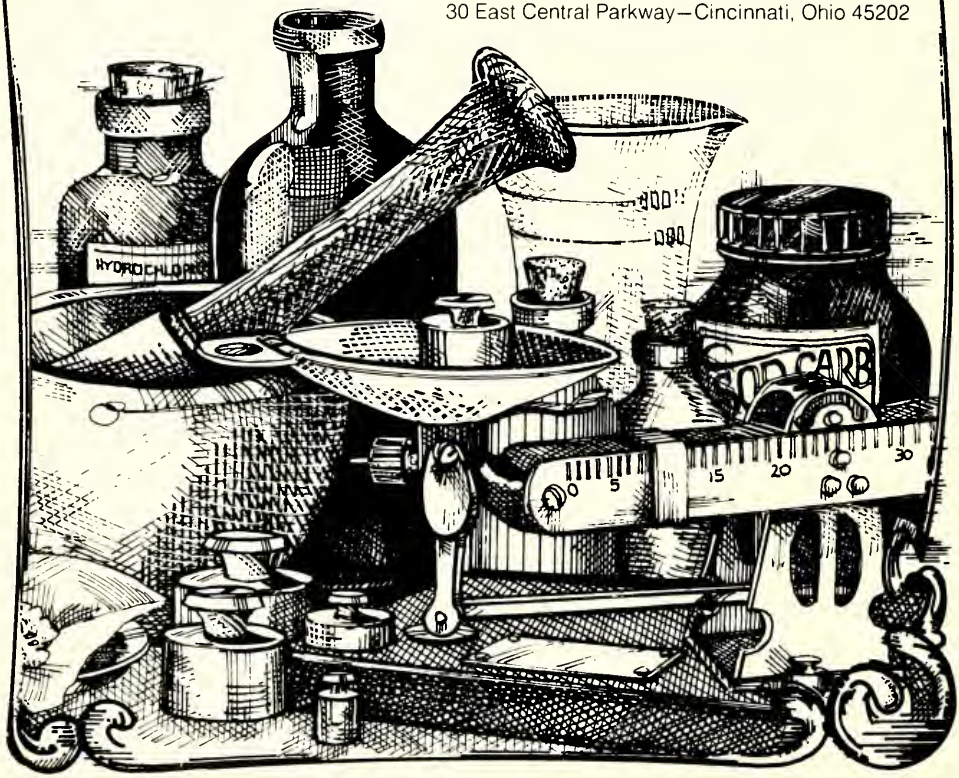

THE CAROLINA JOURNAL of PHARMACY

(USPS 091-280)

JAN-FEB 1982 VOLUME 62 NUMBER 1-2

*

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And when the 10 weeks were over, we parted knowing that we'll enjoy seeing each other in the years ahead.

And reminiscing about the summer of '81.

Upjohn

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1982 CONVENTION-IN-BRIEF

102nd Annual Meeting

N. C. Pharmaceutical Association & Affiliated Auxiliaries

SUNDAY, APRIL 4, 1982

12:00 noon	REGISTRATION DESK OPENS—Lower Lobby
12:30 p.m.	PharmPac Luncheon—Granville Suite
1:00 p.m.	Woman's Auxiliary Hospitality Rooms Open (Suite 233-234)
1:30-3:30 p.m.	Open House-Leeco, Inc.
2:00 p.m.	PharmPac Business Session & Speaker—Regency IV
4:00 p.m.	NCPHA AWARDS SESSION—REGENCY IV
7:30 p.m.	*"Opening Session Dinner"—Regency Ballroom

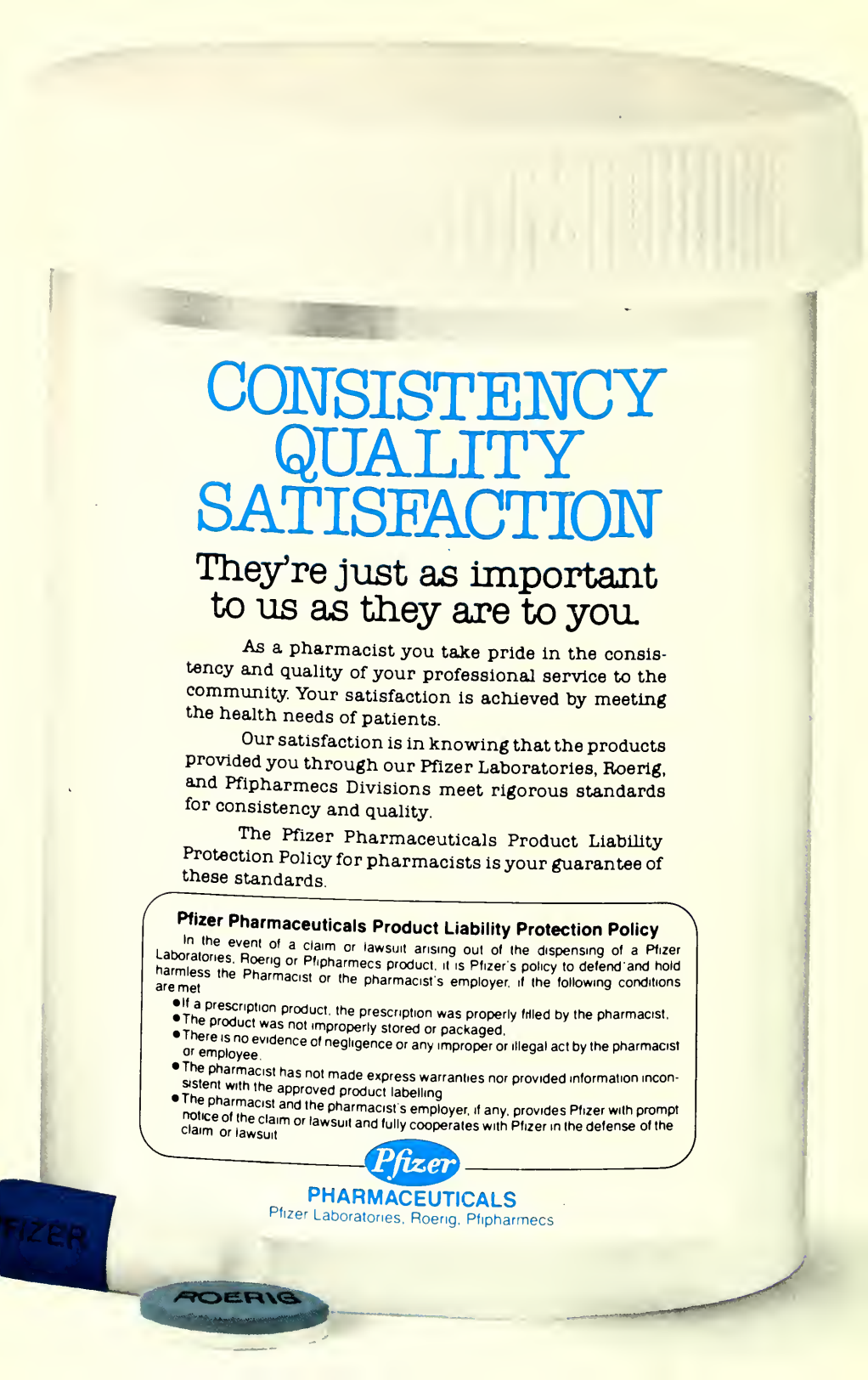
MONDAY, APRIL 5, 1982

8:00 a.m.	REGISTRATION DESK OPENS—Lower Lobby
8:00 a.m.	TMA Foundation Breakfast—Robert E. Lee Room
9:00 a.m.	FIRST NCPHA BUSINESS SESSION—REGENCY IV
9:00 a.m.	Buses leave the Hyatt House for Woman's Auxiliary Tours
12:30 p.m.	Woman's Auxiliary Luncheon—Salem Cotton Company
12:30 p.m.	Academy of Consulting Pharmacy Luncheon—Granville Suite
Afternoon	Golf Tournament—Bermuda Run Country Club
	Tennis Tournament—Bermuda Run Country Club
2:00-4:30 p.m.	Tour of Old Salem OR the Museum of Early Southern Decorative Art
2:00 p.m.	NCPHA WORKSHOPS
	Estate Planning—Regency I
	Food and Drug Interaction—Regency II
	Geriatric Depression—Regency III
2:00 to 5:00 p.m.	Open House—Leeco, Inc.
4:30 p.m.	Tour buses return to Hyatt House
10:30 p.m.	N.C. Drug Wholesalers Ice Box Raid—Garden Terrace

TUESDAY APRIL 6, 1982

7:30 a.m.	Kappa Epsilon Breakfast—Lee*
8:00 a.m.	REGISTRATION DESK OPENS—Lower Lobby
8:30 a.m.	Woman's Auxiliary Coffee—Room 233-234
9:00 a.m.	SECOND NCPHA BUSINESS SESSION—REGENCY IV
9:00 a.m. to 5:00 p.m.	N. C. Board of Pharmacy April Meeting
9:30 a.m.	Woman's Auxiliary Business Session—Regency I
11:00 a.m.	TMA Business Session—Regency III
11:30 a.m.	Tour Buses leave Hyatt House for Bermuda Run Country Club—Ladies Luncheon
12:00 noon	Woman's Auxiliary Buffet Luncheon—Bermuda Run
1:30 p.m.	Tour buses return from Bermuda Run
2:00 p.m.	THIRD NCPHA BUSINESS SESSION—REGENCY IV
7:00 p.m.	*Installation Dinner and "Farmacy Phollies"—Regency Ballroom
9:00 p.m.	TMA Dance—Music by Burt Massengale Orchestra—Regency Ballroom

**Reservations through NCPhA office or registration desk*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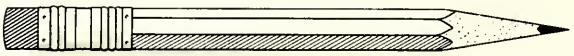

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CONVENTION PROGRAM

102nd ANNUAL MEETING
NORTH CAROLINA PHARMACEUTICAL ASSOCIATION
Winston-Salem Hyatt House
Winston-Salem, N. C.

OPENING SESSION DINNER
Regency Ballroom
Sunday, April 4, 1982
Seven-thirty o'clock
A. C. Dollar, Convention Chairman, Presiding

CALL TO ORDER
North Carolina Pharmaceutical Association—J. Marshall Sasser, President
Woman's Auxiliary, NCPhA—Mrs. Romas T. White, President
Traveling Members' Auxiliary—Leonard G. Phillipps, President

INVOCATION
The Reverend William A. Poole, Executive Director
North Carolina Baptist Homes

DINNER*

WELCOME TO THE CITY
Wayne A. Corpening, Mayor
The City of Winston-Salem

ENTERTAINMENT
The Jazz Quintet, North Carolina School of The Arts

W. J. SMITH CONVENTION SPEAKER
H. F. "Chub" Seawell, Jr.—"The Simplicity of Ignorance"

ANNOUNCEMENTS

ADJOURNMENT

**Dinner reservations available through NCPhA office or at the registration desk*

Mr. and Mrs. A. C. Dollar, Winston-Salem. Convention chairmen for the N. C. Pharmaceutical Association and Woman's Auxiliary, NCPhA, respectively.

MONDAY MORNING

Nine O'clock — First Business Session — Regency IV

Ernest J. Rabil, First Vice-President, Presiding

In Memorium—The Rite of the Roses—Mr. and Mrs. W. A. West
The President's Address—J. Marshall Sasser, President, NCPhA
The N. C. Board of Pharmacy Report—David R. Work, Secretary-Treasurer
Committee Report—Endowment Fund & Consolidated Pharmacy Loan Fund—Jack W. Wier, Chairman
Rx for Pharmacists' Headaches—The Schering Report III—Jack Robbins, Ph.D., Associate Director, Pharmacy Affairs, Schering Corporation
Report of the Ad Hoc Committee on PD Designation—H. Shelton Brown, Jr., Chairman
Attendance Prizes
Adjournment

MONDAY AFTERNOON

Golf Tournament—Bermuda Run Country Club—Sponsored by Owens-Illinois
Tennis Tournament—Bermuda Run Country Club
Open House—Leeco, Inc.—Developers of the Pharmaceutical Information Network System
Meetings:
Committee on Time and Place
Committee on Resolutions
NCPhA Workshops—2:00 p.m.
Estate Planning—Wachovia Bank & Trust Co.—Regency I
Food & Drug Interaction—William T. Sawyer, M.S., Assistant Professor of Pharmacy Practice and Charlotte Area AHEC Pharmacist—Regency II
Assessment & Treatment of Geriatric Depression—Richard A. Hussian, Ph.D., Senior Psychologist, Guilford County Mental Health Center.
Sponsored by Merrell Dow Pharmaceuticals Regency III

MONDAY EVENING

10:30 p.m. **Ice Box Raid**—Sponsored by the North Carolina Wholesale Druggists—Garden Terrace

TUESDAY MORNING

Nine O'clock — Second Business Session — Regency IV

Julian E. Upchurch, Jr., NCPhA Second Vice-President, Presiding

Promoting Your Pharmacy—Cheap, Easy and Effective—Joe C. Miller
Report of the School of Pharmacy and the N. C. Pharmaceutical Research Foundation—George H. Cocolas, Associate Dean
Report of the Student Branch—Susan D. Lee, President
Post Marketing Surveillance and the Pharmacist—Hugh H. Tilson MD, Department Head—Product Surveillance & Epidemiology, Burroughs Wellcome Co.
Positioning of A New OTC Entry—Ted R. Gladson, President of PE Systems.
Sponsored by Burroughs Wellcome Co.
Attendance Prizes
Adjournment for lunch

CONVENTION BADGE REQUIRED FOR ALL FUNCTIONS

TUESDAY AFTERNOON

Two O'clock — Third Business Session — Regency IV

J. Marshall Sasser, NCPhA President, Presiding

Medicaid in N. C.—"An Hour with Benny and Shelton"—C. B. "Benny" Ridout and H. Shelton Brown, Jr.
Report of the Executive Director—A. H. Mebane, III
Committee Reports
Continuing Education
Time and Place
Resolutions
Nominations
Legislation
Greetings from The Woman's Auxiliary—Mrs. Romas T. White, President
Report of the Convention Registrar—Tom R. Burgiss
Attendance Prizes
Adjournment

TUESDAY EVENING

Seven O'clock — Regency Ballroom

Installation Dinner and Farmacy Phollies

J. Marshall Sasser, Master of Ceremonies

Nine O'clock — Regency Ballroom

TMA Dance
Music by Burt Massengale and His Orchestra
Sponsored by The Traveling Members' Auxiliary

CONVENTION CONTRIBUTORS

Programs of Continuing Education are vital to the success of the Annual Convention of the North Carolina Pharmaceutical Association and Affiliated Auxiliaries. This year, we give special recognition to the following companies for substantial contributions to these programs:

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Advisor—Mrs. Shelton B. Boyd
P. O. Box 455, Mt. Olive 28365
Coordinator—Mrs. A. H. Mebane, III
534 Dogwood Drive, Chapel Hill 27514

Mrs. Romas T. White, President

55th Annual Convention

SUNDAY, APRIL 4, 1982

12:00 noon	Registration Desk opens—Lower Lobby
1:00 p.m.	Woman's Auxiliary Hospitality Room 233-34 Opens
1:30-3:30 p.m.	Open House—(LEECO, Inc.)
4:00 p.m.	Awards Session—Regency IV
7:30 p.m.	*Opening Session Dinner—Guest Speaker, Chub Seawell— Entertainment, Jazz Quartet, NC School of Arts—Regency Ballroom

MONDAY, APRIL 5, 1982

9:00 a.m.	Buses begin loading for Woman's Auxiliary Tours
9:30-12:00	Tour of Old Salem OR Museum of Early Southern Decorative Arts
12:30 p.m.	Woman's Auxilary Luncheon—Salem Cotton Company
2:00-4:30 p.m.	Tour of Old Salem OR Museum of Early Southern Decorative Arts
2:00 p.m.	Golf—Bermuda Run Country Club Tennis—Bermuda Run Country Club
2:00 p.m.	NCPhA Workshops Estate Planning—Regency I Food & Drug Interaction—Regency II Depression, Diagnosis, Treatment—Regency III
2:00-5:00 p.m.	Open House—LEECO, Inc.
4:30 p.m.	Buses return to Hyatt House
10:30 p.m.	N. C. Drug Wholesalers Ice Box Raid—Garden Terrace

CONVENTION BADGE REQUIRED FOR ALL FUNCTIONS

TUESDAY, APRIL 6, 1982

8:30 a.m.	Woman's Auxiliary Coffee—Hospitality Room 233-34 Opens
9:30 a.m.	Woman's Auxiliary Business Session—Regency I
11:30 a.m.	Buses begin loading for Bermuda Run Country Club
12:00 noon	Luncheon—Installation of Officers—Entertainment Fashion Show—Fashions by Montaldo's
1:30 p.m.	Buses return to Hyatt House
7:00 p.m.	*Installation Dinner and "Farmacy Phollies"—Regency Ballroom
9:00 p.m.	TMA Dance—Music by Burt Massengale Orchestra—Regency Ballroom

**Dinner reservations and tickets through NCPhA*

Jerry White, President, Woman's Auxiliary, NCPhA, presents a check for $1,000 to J. Marshall Sasser, NCPhA President. The funds are seed money toward the purchase of a computer for the Association central office.

Staff photo

OPEN HOUSE—LEECO, INC.

All convention registrants are urged to enjoy the open house at Leeco, Inc., the Winston-Salem-based software and systems development company specializing in computers for pharmacy. The Open House is scheduled for 1:30 to 3:30 pm on Sunday and 2:00 to 5:00 pm on Monday. Complete information including directions are available at the Registration Desk . . . This will be worth your time. Leeco is the developer of PINS (The Pharmacy Information Network System.)

N. C. BOARD OF PHARMACY

The regular April meeting of the Board of Pharmacy will be held Tuesday, April 6, from 9:00 am to 5:00 pm. The meeting is open to any pharmacist who wishes to attend.

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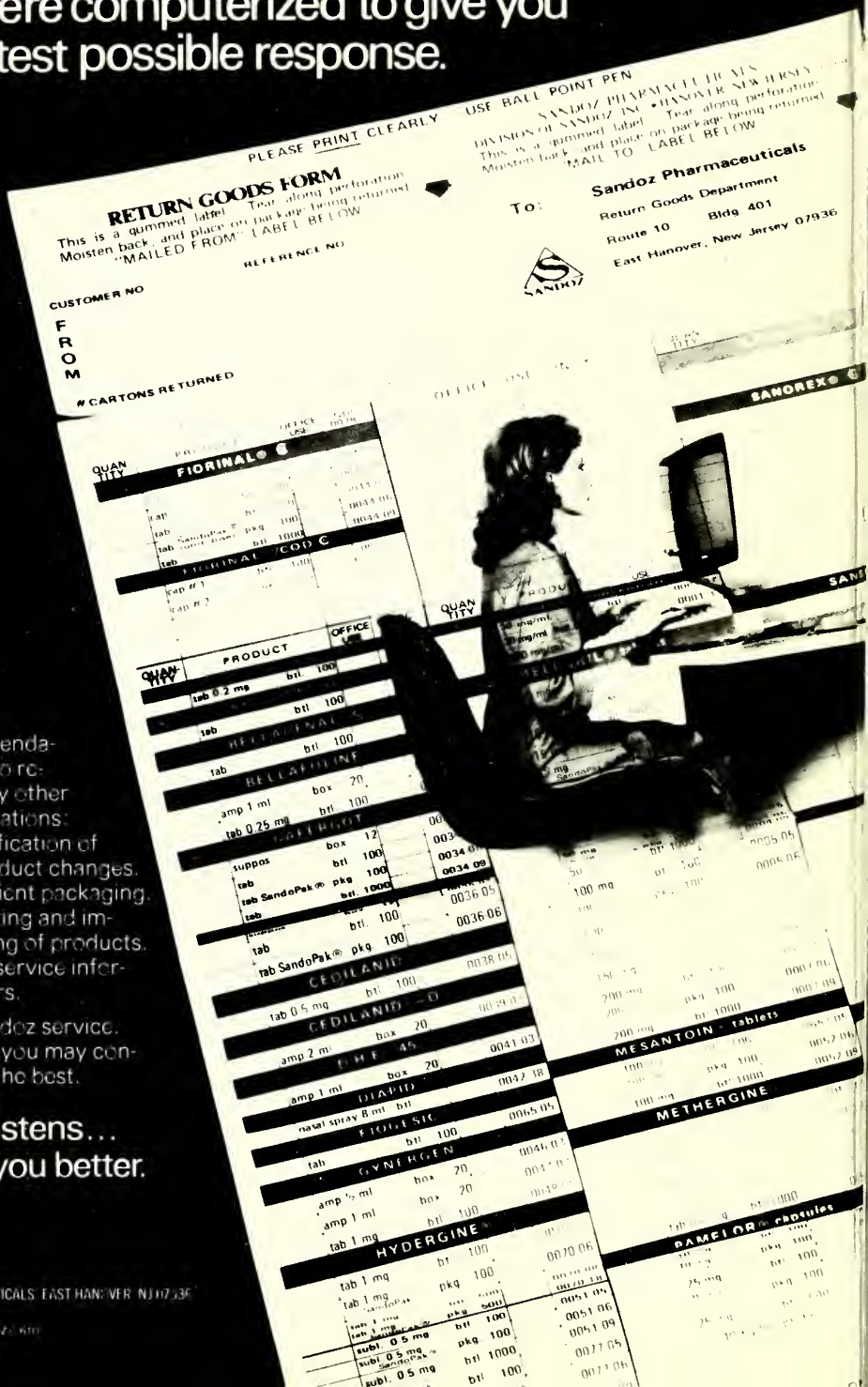

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SUNDAY, APRIL 4, 1982

12:00 noon	REGISTRATION DESK OPENS—Lower Lobby
4:00 p.m.	Awards Session—Regency IV
7:30 p.m.	*Opening Session Dinner—Regency Ballroom

MONDAY, APRIL 5, 1982

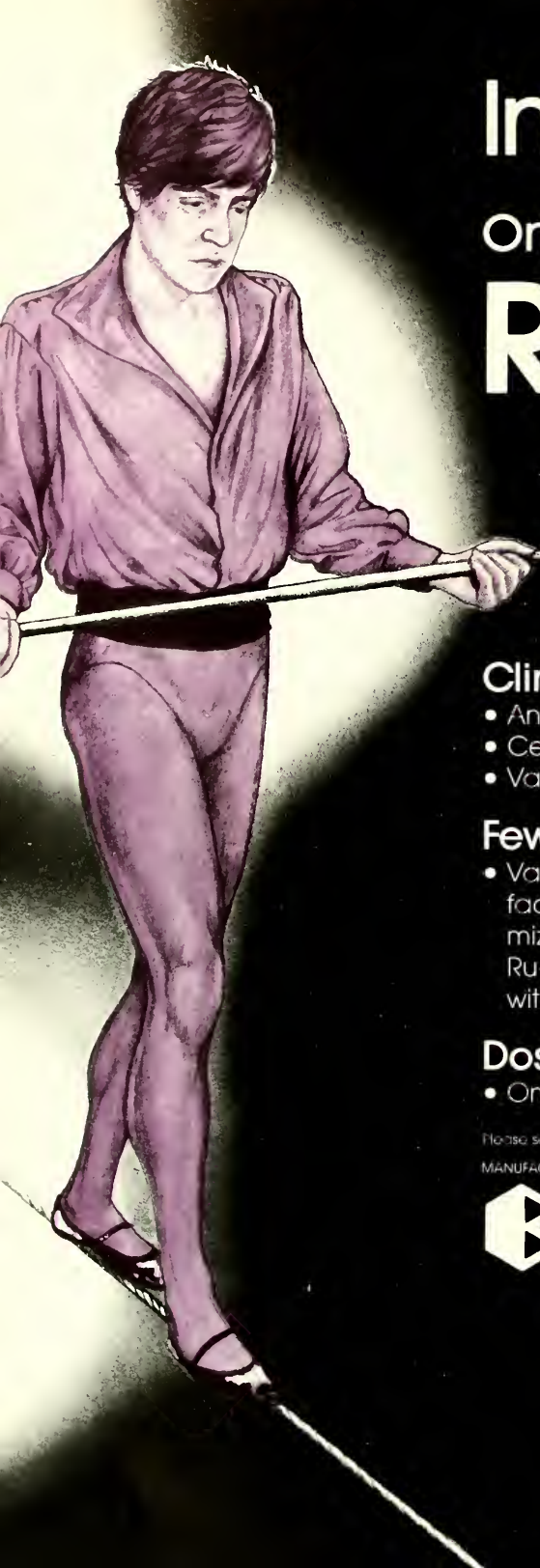
8:00 a.m.	REGISTRATION DESK OPENS—Lower Lobby
8:00 a.m.	TMA Foundation Breakfast—Robert E. Lee Room
	Golf Tournament and Tennis Tournament—Bermuda Run Country Club
10:30 p.m.	Ice Box Raid—Sponsored by the N. C. Drug Wholesalers—Garden Terrace

TUESDAY, APRIL 6, 1982

8:00 a.m.	REGISTRATION DESK OPENS—Lower Lobby
11:00 a.m.	TMA Business Session—Regency III
7:00 p.m.	*Installation Dinner and "Farmacy Phollies"—Regency Ballroom
9:00 p.m.	TMA Dance, Music by Burt Massengale and His Orchestra—Regency Ballroom

**Reservations Through the NCPhA Office or Registration Desk*

All TMA members are cordially invited to attend the NCPhA business sessions and workshops



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Chub Seawell

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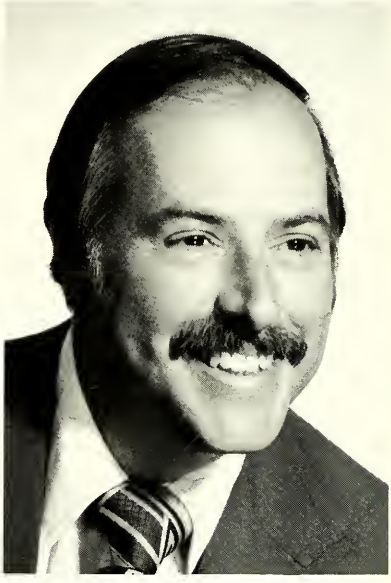
W. J. Smith Convention Speaker
Sunday Night Opening Session
Carthage attorney, Author, Satirist
"The Simplicity of Ignorance"



Ted Gladson

Ted R. Gladson, R.Ph.
President, PE Systems, Inc.
Consultant to manufacturers, wholesalers and retailers in the area of design and merchandising. Sponsored by Burroughs Wellcome Co., he will present the program "Positioning of a NEW OTC Entry"

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Once again, the mysterious and unknown Mr or Madam X will roam the floors of the Convention, anxiously awaiting friendly handshakes. The fiftieth handshake will be worth a cash award of fifty dollars.

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On the modernization and improvement of service at St. Joseph's Hospital Pharmacy, Asheville. We are pleased and proud to have had a part in this project.

H. Warren Spear R. Ph.
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Perspectives in Pharmacy

Patient Drug Information

Presented in the interest of better-informed pharmacy

Neil L. Pruitt, R.Ph.
President
National Association of Retail Druggists

"The delivery of health care in our communities is changing. Traditional institutions are giving way to home health care and outpatient clinics. Handicapped persons with their special needs for durable medical equipment and health supports and appliances require personal attention. The increase in over-the-counter

Neil L. Pruitt, R.Ph.

products that were once prescription-only means that more customers will require counseling on their use. An increasing drug-dependent elderly population will rely more than ever on the professional advice of their pharmacists.

"Patient counseling will become more important than ever before because of the hosts of different populations we are seeing in our stores—the handicapped, the elderly, the teenager who has more money to spend on cosmetics, the consumer who wants to know about the efficacy of the drugs he or she is taking.

"Talking to our customers gives us a unique marketing advantage because we know who they are and what they want. Service is, indeed, one of our keys for survival."

Dorothy L. Smith, Pharm.D.
Director of Clinical Affairs
American Pharmaceutical Association

"The pharmacist has an excellent opportunity to test the patient's recall of the information provided by the physician, to make the prescription instructions readily understandable, and to reinforce the patient's faith in the prescribed therapy.

Dorothy L. Smith, Pharm.D.

"The type and amount of information required will vary with the specific needs of the patient. But generally, patients want enough information to help them complete the therapy *as easily* and *as safely* as possible.

"Almost all patients will have questions about applying the drug regimen to their own schedules. They are willing to modify their daily activities to accommodate a dosage schedule if they understand why the changes are best for them. But these questions can be answered only on an individual basis.

"Handing the patient a full disclosure sheet does not effectively help 'educate.' In fact, a long list of potential adverse effects may even convince a patient *not* to take the medication.

"Every effort must be made not to frighten the patient. Basically, the role of the pharmacist is to help a patient use drugs most effectively and with the least anxiety."

Reprinted from American Pharmacy, Vol. NS 21, No. 7, p. 382.

John F. Schlegel, Pharm.D., M.S.
Executive Director
American Association of Colleges of Pharmacy

"Most pharmacy professionals recognize the importance of communication skills. Indeed, depending on one's particular perspective, personal pharmacy service that emphasizes patient education can be a source of immense satisfaction, enhanced professional image, increased patronage, and improved health care through better understanding and use of medicines.

"Influences both inside and outside the profession point toward a resurgence of personal contact between the pharmacist and the patient. The public's 'right to know' cannot responsibly be denied. The problem has been in finding time in the pharmacy student's busy curriculum for proper communication skills training.

John F. Schlegel, Pharm.D., M.S.

"For the past several years, colleges of pharmacy have been increasing the quantity and quality of training in this area, and greater attention is being paid to the influence of personality types on professional motivation.

"In the future, the 1980's will likely be described as the 'Communications Era' in pharmacy. The profession has made significant advances, but there is still a need for more change."

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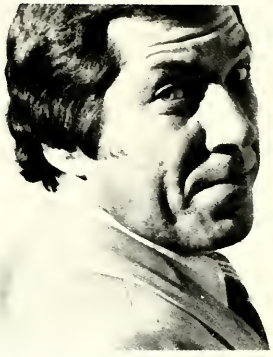

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Carolyn Clayton, Editor

ScRxipt

A THANK YOU

Tom S. Miya, Dean

On January 31st the School had its first Open House in recent memory. It was to honor Associate Dean Werley who has retired after almost fifteen years. Important, however, was the celebration of the first major renovation of Beard Hall. It was also the beginning of my sixth year in Chapel Hill. It is my hope that the almost 700 visitors were pleased at what they saw and, moreover, pleased with the many exhibits depicting our forward-looking programs. For those of you who were unable to attend, feel free to visit us at any time.

Bricks and mortar are important, but what the "new look" reflects is the progress we've made and the signaling of better things to come—yes, better things. Despite the gloomy economic outlook, I am more optimistic today than I have ever been about the future of your School and the pharmacy profession.

My optimism is based on a number of factors, but reduced to the common denominator, it is people. What school can boast about the statewide system we have in our AHEC and the persons involved in it? What school can boast the lineup of Division Chairmen and faculty who are all aggressive, well motivated and many of them nationally known? What school has the working relationships with its sister organizations, viz., the State Board and the Association? What school has the support of a true major university and its chancellor? What school has the great people resource of our one and only Research Triangle Park? What dean has enjoyed the type of work relationship with his associate dean and the assistant to the dean and all the support staff?

Sounds like "Blue Heaven," but as in real life, there are some scattered clouds. These clouds will make the immediate years ahead challenging and the decisions more difficult. I know that the alumni and other supporters are proud of their School. You should be since you helped build it. Your continued support is required to keep it that way.

FACULTY NOTES

CLAUDE PIANTADOSI, Professor of Pharmacy in the Division of Medicinal Chemistry and graduate student JEFFERSON SURLES have published (in collaboration with members of Bowman Gray School of Medicine and Oak Ridge Assoc. University) a paper entitled "Stereospecific Activity of 1-0-Alkyl-2-0- Acetyl-SN-Glycero-3-Phosphocholine and Comparison of Analogs in the Degranulation of Platelets and Neutrophils." The paper was published in the June 30, 1981 edition of *Biochemical and Biophysical Research Communications* (100: 4) on pages 1651-1658.

JEAN PAUL GAGNON, Professor and Chairman of the Division of Pharmacy Administration has co-authored (with graduate student NORMAN CARROLL) an article entitled "A Strategy for Marketing Pharmacy Services" in *American Pharmacy,* Volume NS22, Number 1, January 1982, pp. 53-56.

Associate Professor STEPHEN M. CAIOLA and Clinical Instructors PATSY F. HUFF and SANDRA H. HAK (all of the Division of Pharmacy Practice) have published an article entitled "Immunizations for International Travel as a Pharmaceutical Service" in Volume 39 of the *American Journal of Hospital Pharmacy,* January 1982: 90-93.

MALPRACTICE: A FRIGHTENING REALITY

by Shannon Barbour, 3/5

The following article is the fourth in this year's series of papers selected for publication in Script from papers written by 3/5 students in Pharmacy 21, Drugs, the Pharmacist, and the Health Care System. Opinions expressed in the papers are by no means selected as an official stance of the school of Pharmacy.

Malpractice. The mere thought of this world's implications—ruined reputation, loss of money, and perhaps loss of business—causes many people to shutter. According to Webster's, malpractice is defined as "the treatment of a case by a surgeon or physician in a manner contrary to accepted rules and with harmful results to the patient." Today, however malpractice more generally denotes professional negligence in almost any sector of the medical field. Pharmacists, in particular, are just recently becoming aware of the serious implications connected with malpractice suits. A survey of twenty-three insurance companies reporting on product liability claims in 1977 reported ninety-two successful suits involving prescription drugs and that these suits had the highest average claims. While this should alert pharmacists to the need for extreme care and accuracy in their work, J. L. Fink emphasizes that due to the "myriad of situations which may give rise to a lawsuit, it is impossible to set forth exact and detailed legal standards for every situation a pharmacist may encounter."

Several such legal standards do exist, however. Pharmacy practice is generally regulated by the individual states. State regulations are concerned with maintaining the health, morals, safety, and welfare of its citizens. The North Carolina law states for example: "Every person who shall engage in the sale of drugs . . . shall be held responsible for the quality of all drugs . . . he may sell or dispense, with the exception of those sold in the original packages of the manufacturers . . ."

Along with such explicit legal guidelines exists the ethical concept of the standard of care. G. A. Schwartz states that the standard of care as it applies to pharmacy is of the "highest degree known to practical man." William Prosser, the nation's leading authority on negligence law explains that "the risk of harm created by the activity a person is performing determines the degree of care required . . ." Ultimately, however, it is the jury's unfortunate duty to decide whether the pharmacist's performance met this required standard of care. Clearly, it is one of the toughest value judgments they are forced to make.

In the hopes of alleviating any "gray' areas regarding the pharmacist's responsibilities, the American Pharmaceutical Association has published an official standards of practice guideline. The major obligations of a competent pharmacist include interviewing the patient and maintaining patient medication records, checking prescriptions against records for possible drug-drug interactions, and determining if such potential of interaction exists.

Despite such precautions, lawsuits do and will occur. Pharmacists can be charged for supplying the wrong drug, failing to give adequate warning, misrepresenting a substitute drug, or committing an error in filling the prescription. Once a suit is brought to court, however, the prosecution must prove that the injury would not have occurred anyway, direct causation on the part of the pharmacist (Sanders v. Marigold), and that the patient was not contributorily negligent (Macky v. Crown Drug Co.). Further, the law offers no reward for patients who merely discover the pharmacist's negligence. Though this legal opinion is beneficial to the pharmacist, pharmacists should consult a lawyer in any legally questionable situations as they can make decisions based on previous court rulings.

Competent pharmacists should also continue their education by subscribing to current pharmaceutical journals, attending seminars on new pharmaceutical developments. In fact, twenty-two states have adopted Mandatory Continuing Education requirements for pharmacists.

(continued on page 27)

LeROY D. WERLEY RETIRES

It's hard to believe and difficult to accept but Associate Dean Werley has decided to retire. "A little more time with my wife, time for golf and some woodworking," he said at the dinner given in his honor on January 18. (His official retirement date was January 31.)

Dean Werley has been strong in North Carolina Pharmacy for 14½ years. At the School of Pharmacy, he has held the positions of Assistant Dean, Associate Dean, Acting Dean, Associate Professor of Pharmacy Administration, and Director of Student Affairs. On his retirement, he also stepped down from his post as Chairman of the Board of Scientific Directors of the Institute of Nutrition.

Before coming to UNC-CH, Werley served in the Marines and in the U. S. Air Force where he served as Administrator of Professional Services at Andrews Air Force Base in Washington, D. C. From 1961-66, he was a consultant in professional services and pharmacy to the Surgeon General.

We will all miss him very much.

Peg and Lee Werley

Quote: LeRoy Werley "I will miss interacting with the students most of all."

FACULTY NOTES

Assistant Professor ABRAHAM G. HARTZEMA of the Division of Pharmacy Administration has published (in collaboration with others) an article entitled "Discriminating High and Low Drug Prescribers Among Physicians in an HMO" in the Fall 1981 (Vol. 1, No. 4) issue of *Journal of Health Care Marketing,* pp. 8-17. He has also published a paper entitled "Self-Medication: In the Scheme of Things," in *Pharmacy International,* Vol. 4, 1981, pp. 272-273.

GEORGE H. COCOLAS, Professor of Medicinal Chemistry and Associate Dean was elected chairman of the Lyman Award Committee, a special committee of the American Association of Colleges of Pharmacy that serves to re-evaluate criteria and set up guidelines for the selection of the Lyman Award, an honor given to the best paper published in the American Journal of Pharmaceutical Education.

Malpractice ... from p. 26

Along with the many responsibilities of a competent pharmacist exists the need to stay on top of new trends and developments. Malpractice claims are increasing. However, as long as the pharmacist performs his duties according to expected standards and continues to change with the times, the risk of being charged with malpractice is greatly reduced.

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Schwartz GA. Pharmacy malpractice: the changing standard of care. Amer Pharm 1980 Sept 20; (9): 60-63

Smith MC Ph.D., Knapp DA, Ph.D. Pharmacy, Drugs and Medical Care. Baltimore, Md.: Williams & Wilkens., 1981: 83

Dr. George H. Cocolas, Professor of Medicinal Chemistry is our new Associate Dean and Director of Student Affairs as of February 1, 1982. A search is underway for a replacement for Dr. Cocolas as Chairman of the Division of Medicinal Chemistry.

DRUG INFORMATION REPORTS

New Trends in Pharmaceutical Advertising

I. Pre-approval promotion

Ciba Geigy's Transderm-Nitro® (Transdermal nitroglycerin) pre-NDA journal advertisement stating, "Coming soon a major innovation in cardiovascular medicine—A new addition to the family of Transderm Systems," is an example of the type of preapproval promotion which is acceptable to the FDA. According to the Bureau of Drugs Advertising Director, Peter Rheinstein, M.D., "No drug is named and there is no claim of efficacy or usefulness, . . . Indeed, even if the reader could identify the drug, there is no claim which could be considered misleading. I would conclude that this advertisement would cause us little concern and there would be little basis for regulatory action."

In contrast the FDA has had problems with a Syntex pre-approval promotion for Nasalide® and a Marion campaign for Carafate.® These advertisements promoted safety and usefulness without disclosing contraindications, precautions or adverse reactions.

II. Comparative efficacy claims

Claims of comparative efficacy between products has been a lingering issue between the FDA and Pharmaceutical Manufacturers for several years. Attempts to resolve the issue two years ago came to no conclusion. Recently, Eli Lilly has been challenged by Upjohn and Schering before the FDA for claims of comparative efficacy in the FDA approved product literature. (Nebcin® has been shown to be less nephrotoxic than Garamycin ®; moxalactam was more effective than gentamicin plus clindamycin." Citing prior examples of comparative labeling in product literature (Tagamet,® Ascendin,® Flexeril®), Lilly maintained that FDA approval of a comparative labeling statement does not constitute new policy. After months of meetings, the labeling issue has now been resolved via a voluntary agreement with Lilly for the firm to remove the comparative claim from the label of moxalactam. Claims for comparative efficacy are allowed in promotional advertising. Schering is continuing its objection to the Nebcin® product literature wording.

(continued on page 29)

Drug Information Reports from p. 28

III. Marketing directly to the patient

And yet another advertising trend is the manufacturer-to-patient marketing of insulin. While this practice is legal because of the non-prescription status of insulin in most states (including North Carolina), the undesirability of this practice is evident in the potential for patients to interchange brands of insulin based on advertised claims without proper advice by a physician or pharmacist.

A somewhat more subtle approach in the marketing of legend drugs to the consumer is occurring with ibuprofen. Boots Pharmaceuticals, a British firm, is promoting Rufen® (ibuprofen) in the United States by offering a $1.50 rebate to the patient along with a lower wholesale price to the pharmacist. Boots states in their professional literature that "Patients, too, will probably be learning about the Rufen® rebate program through public interest stories in newspapers, magazines and broadcast media." Predictably their promotional campaign did appear in the lay-press. This marketing program will, in a positive way, decrease the cost of medication to the patient. However negative consequences may also result if patients "pressure" physicians into prescribing Rufen® when it is not medically wise, for instance with patients already well-controlled on anti-arthritic medications other than ibuprofen. The information in the above reports has been extracted from recent issues of F.D. & C. Reports—"Pink Sheet."

John Kessler, Pharm D.
Supervisor of Drug Information Services

The School of Pharmacy welcomes three new Clinical Assistant Professors who joined the faculty October 1981. All are with the North Carolina Memorial Hospital pharmacy. John Kessler (Pharm D., Duquesne University) is supervisor of Drug Information Services. Certainly you will look forward to his Drug Information Reports column which is being re-instituted with this issue of SCRIPT. Jan Childress (MS, University of North Carolina) is Supervisor of IV Admixture Services. Rex Brown (Pharm D., University of Tennessee) is a Clinical Nutrition Specialist.

Left to right: John Kessler, Jan Childress, and Rex Brown in the North Carolina Memorial Hospital Drug Information Center.

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LOCAL NEWS

FIRE DAMAGES CROWN DRUG STORE

Fire heavily damaged Crown Drug Store, Winston-Salem, early Wednesday, December 16, wiping out merchandise purchased for the holiday season and damaging the drugs in the prescription department. According to firemen, the fire had smoldered for several hours before it was reported at 6:40 am. Conrad Stonestreet, principal owner, estimated damage at over $100,000 to the contents but was unable to estimate the damage to the building. Prescription records were not damaged and plans are already underway to set up a trailer in the parking lot to serve as a temporary pharmacy.

DRUG COMPANY TO LOCATE NEAR ZEBULON

A major international pharmaceutical firm is negotiating to build a 30 million dollar plant south of Zebulon, off the U. S. 64 Bypass, to manufacture antibiotics and other drugs.

Glaxo Inc., the U. S. subsidiary of Glaxo Holding Co., the largest pharmaceutical firm in Great Britain with world-wide sales of over $1.5 billion, plans to open the plant in 1985 with about 100 employees. This plant would be Glaxo's only manufacturing facility in the U. S. The 80-acre site is suitable for expansion and the plant is expected to expand to 200 employees by 1990.

HILLSBOROUGH

Evelyn P. Lloyd has been appointed to the NARD Committee on Consumer Affairs and Public Relations by NARD President Neil L. Pruitt. She currently serves as acting secretary of the Historic Hillsborough Commission, in addition to her many other activities.

GUILFORD COUNTY

The January meeting of the Guilford County Society of Pharmacists was held on Tuesday, Jan. 12, 1982 at Wesley Long Community Hospital. Guest speaker for the evening was Joni Berry, M.S., Wake AHEC Pharmacy Coordinator. Ms. Berry, pharmacy consultant for Hospice of Wake County, Inc., discussed the hospice approach to care for critically ill patients, and the pharmacist's role in that care. Her presentation proved to be very informative to all those present.

During the business session following the program, a note from the Greensboro Christmas Clearing Bureau thanking the Society for its $50.00 contribution was read by the Secretary. The slate of officers nominated to serve in 1982 was presented to and approved by the members present. They are as follows:

President—Steve Saxe
Vice-President—Marilyn McConnell
Secretary-Treasurer—Frank Burton
Program Chairman—Peter Gal

Outgoing President Arnie Cherson was thanked for his service during the past year. There being no further business, the meeting was adjourned.

J. Frank Burton
Secretary

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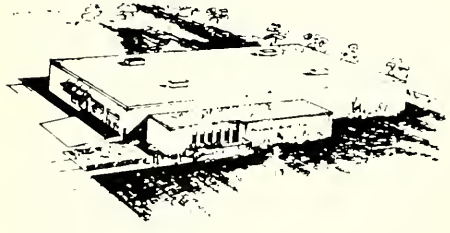

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How Can I Participate?

A pharmacist-manager should simply fill out the prescription summary and supplemental information sections of the *Lilly Digest* participation form and include a copy of his last tax return to provide the needed financial data. All information received will be held in *strict confidence*.

It's Important Because It Helps You Make More Profitable Decisions!!!

The *Lilly Digest* is the only source of comparative operational statistics available. The information it includes can be used as an effective management tool for pharmacist-managers. Participation forms will be in the mail to you soon. Contact the Lilly Analysis Service if you need a form.

LET THE LILLY ANALYSIS SERVICE HEAR FROM YOU!

STOLEN RX BLANKS

Reported stolen are Rx blanks for Dr. David Allan Bobak, Duke University Medical Center. Pharmacists receiving prescriptions for controlled substances (especially Dilaudid) on these blanks should verify the Rx by calling Dr. Bobak at 684-8111 (through February 1982) or 489-5729 (both area code 919).

CHARTER MEMBERS OF THE NCPhA

The North Carolina Pharmaceutical Association was organized in Raleigh in 1880. The initial membership list includes 117 charter members.

Currently, an effort is underway to compile information about each charter member: birth, death and professional career. Comprehensive records exist for about 25% of the charter members.

If you have or can obtain information about these charters members, please mail the details to: W. J. Smith, 908 Arrowhead Road, Chapel Hill, N. C. 27514.

- W. C. Carmichael, Asheville
- L. R. Wriston, Charlotte
- John H. Hill, Goldsboro
- Henry DeB. Hooper, Edenton
- R. M. Johnson, Scotland Neck

Since some of the charter members were doctors, Dr. T. C. Smith of Charlotte, later of Asheville, for example, one or more of the above listed charter members may be medical doctors.

GREENSBORO

Edmonds Drug Store was robbed for the second time in less than a week Wednesday afternoon, September 2, when an armed man escaped with $60 in cash and at least $400 in drugs. The man waited until the store had no customers then pulled a gun on an employee and demanded drugs. He cleaned out the narcotic safe and the cash register.

SYLVA

A local man was arrested and charged with forging prescriptions for controlled drugs. The prescriptions were written for Placidyl and Tylox, according to police.

KINGS MOUNTAIN

An armed bandit escaped with cash and a quantity of controlled substances from the Revco Drug Store, Friday night, July 24.

Group Life And Health Insurance Benefits For Members Of

North Carolina Pharmaceutical Association

Pilot Life Insurance Company is pleased to have been selected as the Group insurance carrier for the North Carolina Pharmaceutical Association. It would be to your advantage to become thoroughly acquainted with the benefits of this program.

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Write or call:
Sam P. Stuart, CLU
1012 Glade Street
Winston-Salem, NC 27102
Telephone 919/723-8811

Pilot Life

NORTHEASTERN CAROLINA PHARMACEUTICAL SOCIETY

Approximately 21 pharmacists attended our October meeting at the Holiday Inn in Williamston on the 14th. Our speaker was the past-President of the NARD, Mr. Jesse M. Pike. Jesse presented a very interesting talk on the NARD and pharmacy today. A point in his talk about DESI drugs and our problems with Medicaid in the state produced some lively discussion afterwards. In other business of the club the members elected officers for the 1982 year as follows: President: Charles E. Woodard, Vice President: James B. Bryant, and Secretary-Treasurer: Charles Wilson. Our next regularly scheduled meeting will be our annual Christmas party with our wives and dates included.

James B. Bryant, Sec-Treasurer

UNC SCHOOL OF PHARMACY EMPLOYERS' DAY

Each year the School of Pharmacy sets aside one day for prospective employers to meet with graduating students.

This day is Friday, March 26, 1982. There are approximately 125 graduating seniors, many of whom will be seeking employment. Informal interviews and personal data forms will assist employers choose students for available positions and future positions.

Anyone wishing to participate in this program should contact—Jack K. Wier, School of Pharmacy, 919-966-1121.

McGEE JOINS FIRM

Store Fixtures and Planning, Inc., Charlotte, N. C. is pleased to announce that Mr. Ray McGee has joined the Company as Pharmacy Planning Specialist for eastern North Carolina. Ray has spent all his working life associated with retail pharmacy, from owning his own drug store in Georgia to the position of National Sales Manager of a national Drug Wholesaler's Manufacturing Division. Ray has spent the past several years as pharmacy design consultant based in Atlanta, Georgia. Mr. McGee has accumulated a vast knowledge of all aspects of retail pharmacy. He welcomes the opportunity to assist Eastern North Carolina Pharmacists with their store planning, fixtures and merchandising needs. Ray and his wife, Martha reside at 6701 Wannamaker Lane, Charlotte, NC.

Officers of the Northeastern Carolina Pharmaceutical Society.

Left to right—Howard Garrett, past president; James B. Bryant, Vice-President; Charles E. Woodard, President; Charles M. Wilson, Secretary-Treasurer; J. Marshall Sasser, President—North Carolina Pharmaceutical Association.

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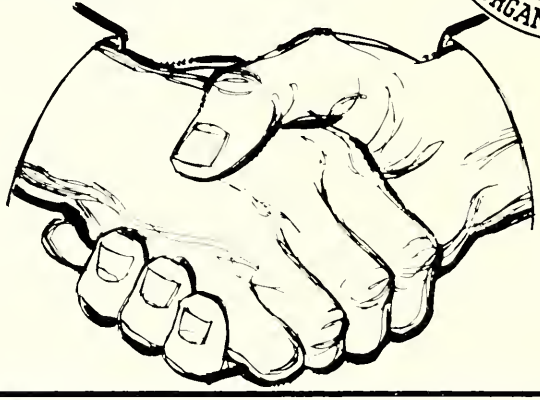

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1981 APPROVED NEW CHEMICAL ENTITIES

Generic Name	Trade Name	FDA-listed Indication
Albuterol	Schering's Proventil	Bronchodilator
Alprazolam	Upjohn's Xanax	Antianxiety
Alprostadil	Upjohn's Prostin VR	Palliative therapy to maintain ductus arteriosus in newborns
Amiloride hydrochloride	Merck's Midamor	Anthihypertensive
Atenolol	ICI Americas' Tenormin	Antihypertensive
Bethanidine sulfate	A. H. Robins' Tenathan	Antihypertensive
Buprenorphine	Eaton's Buprenex	Narcotic analgesic
Captopril	Squibb's Capoten	Antihypertensive
Cefotaxime sodium	Hoechst-Roussel's Claforan	Antibiotic
Ceruletide	Adria's Tymtran	Antiulcer
Estramustine phosphate sodium	Hoffmann-LaRoche's Emcyt	Antineoplastic
Flunisolide	Syntex's Nasalide	Symptoms of seasonal rhinitis
Gemfibrozil	Warner-Lambert's Lopid	Lipid regulating agent
Halazepam	Schering's Paxipam	Antianxiety agent
Isosulfan blue	Hirsch Industries' Lymhazurin	Lymphatic contrast agent
Ketoconazole	Janssen's Nizoral	Antifungal (internal)
Mezlocillin	Miles' Mezlin	Antibiotic
Moxalactam disodium	Lilly's Moxam	Antibiotic
Nifediine	Pfizer's Procardia	for angina
Piperacillin sodium	Lederle's Pipracil	Antibacterial
Saralasin acetate	Norwich-Eaton's Sarenin	Detection of angiotension II-dependent hypertension
Secretin	Kabi Group's Secretin-Kabi	Pancreatic diagnostic
Sucralfate	Marion's Carafate	Anti-ulcer
Sulfadoxine (Pyrimethamine)	Hoffmann-LaRoche's Fansidar	Antimalarial
Temazepam	Sandoz's Restoril	for insomnia
Trazodone	Mead Johnson's Desyrel	Antidepressant
Verapamil	Knoll's Isoptin and Searle's Calan	Supraventricular tachyarrythmias

Dear Pharmacist Colleague:

At its monthly meeting on January 5, 1982, the Wake County Pharmaceutical Association was presented with the following resolution:

WHEREAS, a class action suit seeking a permanent restraining order against the four Rx/month limitation for Medicaid recipients in N. C. (titled: Medicaid Recipients vs. State of N. C.) will soon be filed in Federal court, and

WHEREAS, the legal fees charged for this suit are being paid by individual pharmacists and other interested parties, and

WHEREAS, the NCPhA has officially endorsed the concept of this suit by encouraging and soliciting financial support and helping collect relevant materials, such as affidavits, and

WHEREAS, the four Rx limitation adversely affects many Medicaid recipients in Wake Co., and therefore almost every pharmacist in Wake Co., and

WHEREAS, the Wake Co. Pharm. Assoc. cannot legally contribute monies directly to this suit,

Be it resolved by the Wake Co. Pharm. Assn. that:

(1) it goes on record supporting the class action suit against the four Rx limitation for NC Medicaid recipients, and

(2) A letter be sent from the Assn. to every pharmacist in Wake Co. soliciting contributions to this class action suit by making a check payable to "Jenkins, Lucas, Babb, and Rabil" and mailing it to 350 NCNB Building, Winston-Salem, NC 27101.

The resolution was unanimously adopted and the officers were duly enjoined to carry out the intentions of the resolution.

Norm Johnson

ASSOCIATION-APPROVED COLLECTION AGENCY NAMES NEW REGIONAL MANAGER

St. Paul, Minnesota . . . Norm Johnson has been named a regional manager for I. C. System, Inc., the association-approved collection service. Johnson supervises all sales and service operations in the four-state Piedmont Region—North Carolina, South Carolina, Virginia and West Virginia. His appointment was effective October 1.

Johnson was a top field representative for I. C. System prior to moving into management in January of 1981. At that time he was named divisional manager in southern Texas, where he served until this most recent appointment.

Nationally, I. C. System currently recovers an average of one million dollars per week for its clients, most of whom are members of the 1030 associations that endorse I. C. for use by their members. I. C. System, established as a collection agency in 1938, has collected over $15 million in the Carolinas and Virginias.

1982 PUBLICATION PLANS FOR USP DI ANNOUNCED

The United States Pharmacopeial Convention, Inc., has announced that the next edition of *USP Dispensing Information (USP DI)* will be available in July 1982, and will be labeled "1983."

There will not be a "1982" *USP DI;* instead, all new information will be incorporated into the 1983 edition. This will allow the phase in of *USP DI's* new publication schedule which, starting in 1984, will coincide with the calendar year.

A number of changes will be evident in the 1983 edition of *USP DI.* Of greatest significance, *USP DI* will be divided into two separate volumes. Volume I will contain drug information directed to the health care provider, while Volume II will contain the corresponding lay-language advice for the patient section. In past editions, both sections were in a single volume.

The total number of pages in the 1983 *USP DI* will be double that found in the 1980 edition and will represent a 50% increase over the current edition. Monographs covering more than 100 additional generic agents have been added including, among others, vitamins, antacids, androgens, anabolic steroids, carbonic anhydrase inhibitors, neuromuscular blocking agents, antimyasthenics, and newly marketed drugs.

Information on indications of use, pharmacokinetics and overdose have also been expanded in the 1983 *USP DI.*

Although the hundreds of experts working with the *USP DI* System are volunteers, the increasing cost of support services and printing the new, expanded volumes will require an increase in price. The two volume 1983 *USP DI* will be available for $37.95.

In response to the increasing number of pharmacists, physicians, hospital and nursing home personnel who use the *USP DI* System as part of their patient education programs, additional copies of Volume II *(Advice for the Patient)* may be purchased separately for $17.95.

The 1983 *USP DI* may be ordered through the North Carolina Pharmaceutical Association, P. O. Box 151, Chapel Hill, NC 27514.

DEATH

WALTER LEE MOOSE

W. L. Moose, Mt. Pleasant, died Thursday, October 29, 1981 at the Church of Christ Retirement Center in Newton. He was 83.

Born in Cabarrus County, Mr. Moose was a graduate of the University of Maryland School of Pharmacy and served on the North Carolina State Board of Pharmacy from 1931 to 1936. He was a retired chemist with Vick Chemical Company in Greensboro where he worked from 1942 to 1963.

Moose was an avid photographer of wild flowers and served at one time as an Itinerant Instructor in Pharmacy of the Retail Drug Institute. He is survived by his wife, sister, and brother Hoy A. Moose.

BIRTH

Natalie Claire Evans was born to Mr. & Mrs. Steven C. Evans, Kill Devil Hills, on January 19, 1982. Steve is a 1975 graduate of the UNC School of Pharmacy and is pharmacist-owner at Beach Pharmacy in Nags Head.

CHARLOTTE PHARMACEUTICAL AUXILIARY

The year has been an exciting one for the Charlotte Pharmaceutical Auxiliary. Mrs. Alice Berman Winslade of FACES, INC. was the speaker at the October 13th luncheon meeting at the YWCA. The president of the auxiliary served as a model for a make-up demonstration.

On November 13th the annual holiday bazaar was held. Mrs. W. K. Gardner reported $339.75 proceeds.

At the Christmas program on December 8th a member, Mary Lou Davis, soprano, presented a delightful program. She was accompanied by her aunt, Mrs. Lucinda Davis at the piano.

Jewel Oxendine and her husband Jesse reported the profit from the sale of Christmas trees was $250.00—a job well done! Proceeds from the raffle of a lovely green and gold afghan made by Mrs. R. W. Smith, Jr. was $240.00. Mrs. Douglas T. Corwin reported $37.40 was made from attic sales.

Margaret Smith's husband, Grover is in Mercy Hospital. Two members, Mrs. C. H. Smith and Mrs. H. L. Bizzell are home now after having been in the hospital.

Mrs. Adrian E. Galloway, Chairman of Fun Day reports that a great time is in store for members on March 9th.

Mrs. Edward C. Anselment
President

PRE-REGISTRATION PAYS

One of those pharmacists who pre-registers for the 102nd Annual Convention of the North Carolina Pharmaceutical Association and Affiliated Auxiliaries prior to March 26 will receive an award of FIFTY DOLLARS, courtesy of Cooper Drug Company, Inc., Madison Heights, Michigan. Names of the pre-registrants will be placed in a box and one will be drawn prior to the "Opening Session Dinner" Sunday night, and the fifty dollar award will be presented by Tom Burgiss, Convention Registrar.

50+ Pharmacists who have been licensed for fifty years are eligible for induction into the NCPhA 50+ Club. If you were first licensed in 1932, and are a member of the North Carolina Pharmaceutical Association, please contact this office. A certificate of membership and a lapel pin will be presented to you at the annual convention in Winston-Salem.

The North Carolina Pharmaceutical Association office in Chapel Hill will be closed during the Annual Convention in Winston-Salem, Sunday, Monday, Tuesday and Wednesday.

CLASSIFIED ADVERTISING

Classified advertising (single issue insertion) 10 cents a word with a minimum charge of $3.00 per insertion. Payment to accompany order.

Names and addresses will be published unless a box number is requested.

In replying to "blind" ads, address Ad. No., Carolina Journal of Pharmacy, P. O. Box 151, Chapel Hill, N. C. 27514.

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1981 Mobile Unit, 14 x 48, 8 foot ceiling, 2 x 4 construction, G.E. heat pump, all wiring is complete, commercial front door and carpet. Used for drug store for seven months. Contact: John Hood 107 Avery Ave., Morganton, NC 28655. Telephone: 704-433-6353.

Relief Pharmacist Available in Raleigh, Durham, Chapel Hill area. Flexible schedule. Contact: Ron Salem, 967-6546.

Pharmacist, age 43, married, very settled. Has 20 yrs. experience in Pharmacy in independent & chain stores, desires to purchase small independent store or half (50%) interest in a store w/another Registered Pharmacist. Any area. Contact: NCPhA Box A4.

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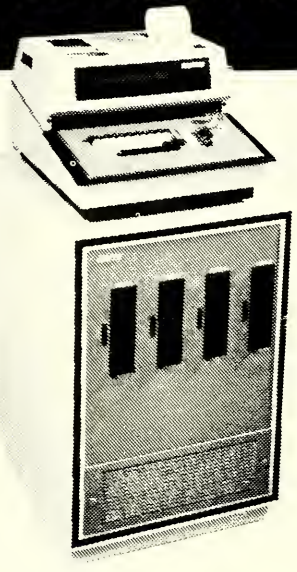

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s in the "Pd or Not PD" debate, presented at the mic Seminar. Left to right, Jesse M. Pike and Frank h, Pro and Con respectively.

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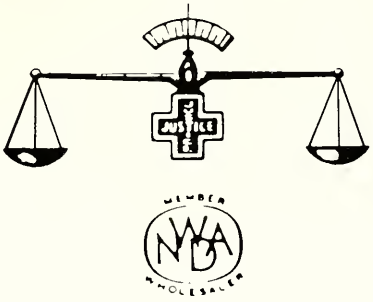

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PD or NOT PD—CON

Presentation by Frank F. Yarborough
Wednesday, February 17, 1982
Sixteenth Annual Pharmacy Seminar on Socio-Economic Aspects of Pharmacy Practice

MY FELLOW PHARMACISTS:

Like many of you in the audience, I grew up in a small town with one "Drug Store" as they were called in those days. The Drug Store was the center of social life in the town, at least during the daytime. You could go there any time of the day and find someone you knew and could socialize with. The owner of the Drug Store was a special person respected by everyone. He performed services that were not available anywhere else. In addition to medicines, he sold everything from bubblegum to flashlights. Little did I know, as I admired the druggist, that someday I would be one.

When I finally enrolled in pharmacy school, I felt like I had reached the top. This was the field I had chosen for all of my working career. I couldn't imagine anything better, that is until I had my Pharmacology Class in the medical school. It was here that I first experienced the "White Coat Syndrome."

One day between classes as several of us stood around the coke machine traveling for quarters, a group of medical students passed us. We stood silent and awestruck as they walked by, each of them wearing a clean freshly pressed white lab jacket, each pocket filled with some type of medical looking object.

I could hardly wait when it was announced that we would be getting our own white jackets for pharmacy lab. I wore mine to Pharmacology Class the next day and stood outside class with my head held high as the first group of medical students walked by, knowing full well that they would acknowledge me when they saw that I too had on a white coat. However, this was not to be. My coat was just as white and pressed as theirs, but something was just not the same. Then I realized what the difference was. They had something in the pockets.

When the next class came, I was prepared. I had gathered up pens and pencils of all kinds, each with the name of one of the drug companies printed on the side, and I was ready. However, I was disappointed again. My white coat was still not the same. It was then that I realized the real difference. I didn't have a stethoscope. . . .

I left class that day dejected and disappointed. I knew my white coat would never be the same, because I could never have that stethoscope, and I don't think I'm the only one who suffered from the "White Coat Syndrome," because even today people stand in awe of anyone with a stethoscope. We are still working hard to gain acceptance by physicians and nurses, the health professionals who wear the stethoscopes around their neck.

I use the term stethoscope to symbolize what today's pharmacists desire. The "Stethoscope Profession," medicine and nursing, seem to have the respect of the public that we desire. We not only crave the respect of the public, but also that of our fellow health professionals as well.

However, beauty is always in the eyes of the beholder. A recent Gallup Poll ranks pharmacy second in honesty and ethical standards in a list of 24 professions and occupations with fifty-nine percent of those polled giving pharmacy a "very high" or "high" ranking compared to a fifty percent rating for medical doctors, who placed fourth behind dentists. Only clergymen topped pharmacists in this poll.

If the general public has this high opinion of pharmacists then who are we trying to convince. As Pogo has so appropriately said, "we have met the enemy and it is us." Unfortunately our problem is not that we do not have the respect of the public or our fellow health care professionals, but that we do not have the respect in ourselves that we desire or deserve.

Let me quote from Jere Goyan, former FDA Commissioner, on the subject of Pharmacist Self Respect: "another clue that pharmacists may lack pride in their role is provided by the P.D. (Doctor of Pharmacy) issue. It is now well known that several state associations and many pharmacists believe that they can (and should) be given the title of P.D. It is their contention

(Continued next page)

PD or NOT PD—CON—cont.

that they are entitled to do so, and that it will catapult them into glories heretofore unknown. I am sympathetic with their desire for recognition, but cannot accept the means by which they would achieve it. In my view, the P.D. movement is indicative of a social disease within the profession, a desire born of lack of self esteem to achieve stature via title. Buried deep within the profession is a festering lack of recognition of its own merits, and a lack of awareness that actions will always speak greater than words (or titles)."

There are, in fact, a number of our profession who see the answer to our problem as the title or designation P.D. or Doctor of Pharmacy. They say the title would give us respect from the public and other health professionals that we do not now have, would raise our own self esteem, would give us financial security, and would help us in negotiations with third party programs.

They also tell us that we are deserving of the title because of the years of experience that we have incurred on the job. Granted we have learned a lot behind the prescription counter, and sometimes in front of it. But a lot of other people in our society have acquired a good deal of knowledge from on the job experience and continuing education programs. There are plumbers with tremendous knowledge gained on the job, as well as electricians, carpenters, nurses, CPA's and engineers. Each of these may consider themselves learned, and may also consider themselves teachers, but certainly do not consider themselves deserving of the title "doctor" because of their experience.

Let me take time to read to you the introduction of the article "Once Upon a PD" by Robert L. Day, Associate Dean for Professional Affairs and Continuing Education at the University of California School of Pharmacy, San Francisco, California, because the account is so reminiscent of what is going on in pharmacy today.

> In May of 1901, the faculty of the California College of Pharmacy (now the School of Pharmacy, University of California), met for the purpose of tidying up some unfinished business. It had to do with the circular distributed several months earlier announcing the upcoming school term. Never a school known for its humility, its aforementioned circular carried the following message.
>
> > 'Again the California College of Pharmacy takes a step forward. The advance this time is in two directions: First, in the entrance requirements which hereafter include two years of high school work and secondly in the inauguration of a post-graduate course for the degree PD or PhM.'*
>
> The problem, as revealed by the asterisked footnote, was: 'The name of the degree has not been fully determined.'
>
> In fact, the names of the degrees had been agreed upon. PD was to mean Doctor of Pharmacy: PhM represented Masters in Pharmacy. The issue really was which degree should be conferred upon those persons who had completed the two year PhG (Graduate in Pharmacy) program, and who returned to take a one-year postgraduate program.
>
> The faculty of that era was a spunky blend of practitioner/educators—many of whom owned and operated their own pharmacies—and it must have been a lively meeting. The simple fact that the circular mentioned both degrees suggests that the battle lines had already been drawn. Yet, the minutes tell us that:
>
> 'After a full discussion, it was deemed that the degree Dr. of Pharmacy would be most in accordance with the practice that had been established by the Colleges in the East, and it was so determined by the consent of all present. The meeting was adjourned.'
>
> Thus the PD degree came to California.
>
> Two graduate pharmacies initially enrolled in the program, an event that takes on significance only when one recalls that in 1901, attending a college of pharmacy was not a requirement for licensure.

(Continued next page)

PD or NOT PD—CON—cont.

> Things went well for nearly a year, but something was brewing. The new degree loomed large in the faculty's mind, as the minutes of the faculty meeting of April 3, 1902, tell us:
>
> 'The Dean said that he had been asked by one of the Directors (of the college) whether we did not think that it would be best that the degree of Dr. of Pharmacy should be conferred upon ourselves at this time, and the Faculty unanimously agreed that such a course would be proper. The meeting was adjourned.'

Perhaps they can be excused for their folly; even today a faculty would feel ill at ease about awarding a degree higher than its own.

In May the class graduated and two PDs were awarded. Their records were forwarded to the parent campus. The University of California in Berkeley . . . and the axe fell. It seems that the college had not bothered to inform the boys upstairs about the new degree.

Within two weeks of the commencement exercise, the dean found himself on the president's carpet. He was told in no uncertain terms that academic degrees—especially doctorate degrees—were not whimsically created in smoke-filled rooms. Such a degree had to be carefully planned and approved by the Academic Senate. Plainly, the PD failed on both counts. The college was ordered to call back the bogus degrees, and the faculty was advised that they had better not call themselves PDs either.

Thus, with probably a great deal of grumbling, the PD left California. One by one, the "Colleges in the East" dropped it as well."

(Continued next page)

CONGRATULATIONS TO

PAUL TUTHEROW AND VIC DELAP

on the new pharmacy at Annie Penn Memorial Hospital in Reidsville. We were pleased to have been a part in the execution of this project.

H. Warren Spear R. Ph.
Pharmacy Design Specialist
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PD or NOT PD—CON—cont.

That was the end of PD for a time, but now it is back, and it is just as inappropriate now as it was then.

We are told that we are doing what every other profession has done in designating ourselves doctors. Medical doctors have designated themselves MD's, lawyers have designated themselves JD's, dentists have designated themselves DDS and so on. However, we are omitting one important difference. These professionals have the degree to match the designation. We are not told that we would be the only profession with a Baccalaureate Degree and a doctor designation.

We are told that as a profession we have a right to call ourselves anything we want. If you don't believe it, NARD will send you a certificate designating you a Doctor of Pharmacy for $15.00. When you get your certificate, how many of you expect to get a raise? This is the same NARD calling themselves The National Association of Retail Druggists. Perhaps next year NARD will call itself the National Association of Retail Doctors.

Pharmacists in our neighboring State of Virginia believe in spending the money differently. They pay about $30.00 a year to their professional guild, which is a fancy title for a union. The guild in turn negotiates with the various drug chains for their salaries. This year the guild negotiated with one of the chains for a salary for non-managerial pharmacists in excess of $30,000 a year. This might seem to be a better investment than $15.00 for a P.D. certificate.

When one assumes a title, one must be prepared to assume the responsibility. Is the group that is proposing PD the same one that denounced PPI's, saying that this was not the pharmacist's responsibility. And what is the organization's stand on mandatory continuing education?

There is nothing wrong with the title "Doctor." There is something wrong with any title that has not been appropriately earned. Let those that desire the title Doctor of Pharmacy do it by the appropriate educational route. With the degree behind the title, we will be adding dignity and uniformity of standards to our profession. The PharmD. degree is not solely the province of the hospital based clinical pharmacist. This degree can be earned in the area of *Community Pharmacy* as well as in the other specialty areas. This specialty should be encouraged and upgraded in the pharmacy schools, just as the medical schools and medical boards have accepted medical family practice as a specialty so as not to have two classes of physicians.

Now What About the Problems with Being a Pharmacy Doctor

The public is accustomed to thinking of a doctor as meaning medical doctor. What will happen when someone advertises that Dr. John Smith will hold a blood pressure or diabetes screening at Jones Pharmacy. Or how about the advertisement on television that states that every prescription at X Mart is filled by a licensed doctor.

There will also be a different situation concerning liability on O.T.C. products. If the doctor title does in fact increase the patient's confidence in the pharmacist, there will be an increase in the requests for O.T.C. prescribing. There will be an increased pressure on the pharmacist to live up to the title of doctor (meaning healer) and he will therefore be held responsible by the patient for any unwanted consequences. The potential for increased liability is tremendous. Can't you see the little old lady looking up at you when you tell her that you don't have anything to treat an earache with and she tells you "why don't you, you're a doctor, aren't you?"

I won't dwell any longer on this subject, but we are creating a different animal with the doctor title, and I am afraid that this animal could turn out to be the monster that we will find out we don't want any part of.

The issue of the designation PD will not evoke cries of opposition from those who do not support it, whether in the pharmacy profession, the medical profession or the general public. I am afraid this will be another case of the silent majority, which will choose not to waste time or effort campaigning against the issue. I have personally chosen to speak against the case. Spare me being called something I do not deserve and do not want unless I have earned it.

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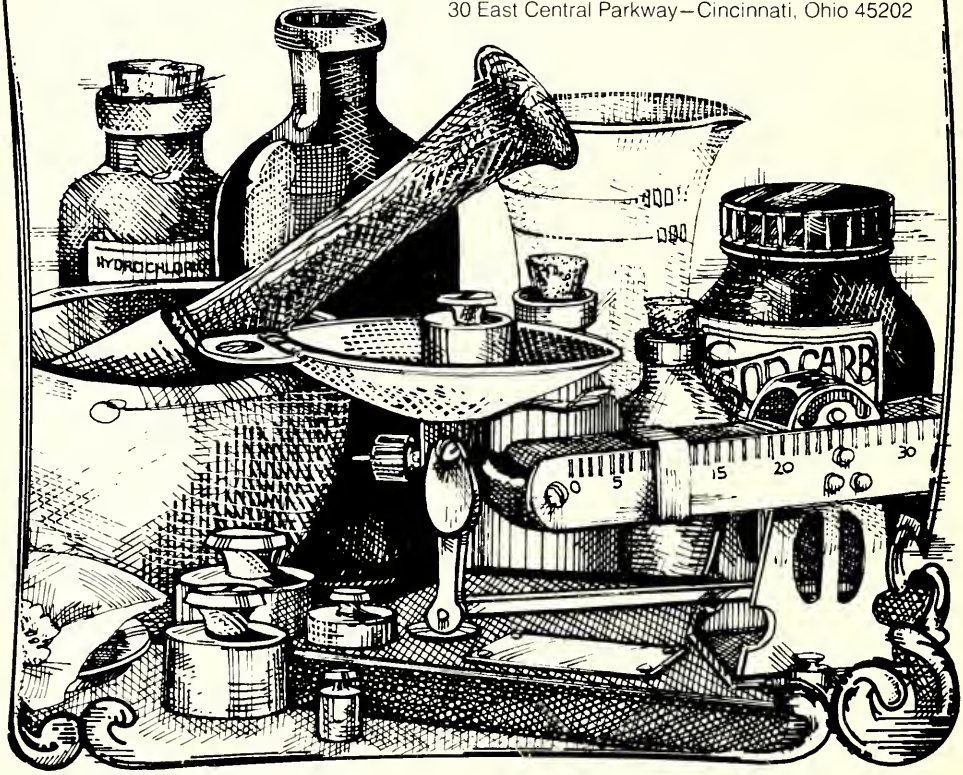

PD or NOT PD—PRO

Presentation by Jesse M. Pike
Wednesday, February 17, 1982
Sixteenth Annual Pharmacy Seminar on Socio-Economic Aspects of Pharmacy Practice

MY FELLOW PHARMACISTS:

Why is this subject, the designation of the P.D.—or Doctor of Pharmacy designation—to indicate a graduate of Pharmacy School—so important to us *at* this time?

From the standpoint of timeliness the importance *and* significance of the designation P.D. has fresh impact as never before in this century.

Historically, it is uncontestable that the original health providers were either physicians or pharmacists—and both practitioners sprang from the same roots.

As more than internship to acquire medical qualification became the rule, a formally structured program began to evolve. Eventually the Philadelphia College of Arts and Science emerged, and has since played a most important role in pharmaceutical education under the leadership of Dr. Joseph Remington—whose name we all recognize. The pharmaceutical leaders of that day adopted the initial graduate of pharmacy and title as "Doctor of Pharmacy." It is the obligation of practitioners to establish the title of the practitioners of each profession. Thus, the "Doctor of Medicine" designation was chosen by physicians and the "Doctor of Pharmacy" designation was selected by pharmacists.

Shortly before World War I, the educators in structuring the emerging evolution of formal pharmaceutical education, assumed a dominant role in pharmaceutical education. It was argued that the shorter time for pharmaceutical education did not fit into the conventional structure of education and to meet this need, the designation of pharmaceutical chemist, or pharmacy graduate, was adopted. In doing this, the wisdom of Dr. Remington was aborted, and that of our educators was accepted by default. The death of Dr. Remington signaled the beginning of educational efforts to change the direction of recognizing graduates in Pharmacy.

About 1932, for most schools, the conventional academic system of acknowledging academic progression was instituted and universities took steps to set up B.S. programs as the initial pharmacy graduate degree—then the M.S.—and eventually Ph.D. degrees. This was fine. It met all the criteria of formal education. It really put the pharmacist out front. Why with good luck, one could probably get a starting salary of $15 dollars a week—or when he became very proficient and acquired his internship and ultimate licensing, the salary had advanced to $25 dollars a week for the average employed licensed pharmacist. Recently I was reviewing a Carolina pharmacist magazine of 1940. W. J. Smith weighed about 140 lbs, and became our Association Secretary. Then the convention was meeting in Charlotte at the Hotel Charlotte where the rooms were advertised at $1.50 single without bath or $2.50 including a bath—and pharmacists had really arrived. We were now B.S. degree holders. Well, history has certainly moved along. Next came the B.S. degree in Pharmacy awarded after 5 years of study plus internship, before licensure as a licensed pharmacist!

Federal grants became the order of the day. Clinical pharmacy became "The Thing" ignoring the fact that most practitioners up until that time had accepted its responsibility and assumed counciling with patients under the title and responsibility of practicing pharmacy. Soon real responsibility of shaping up pharmacists in the retail manufacturing, or hospital duties came during the students 5th undergraduate year. Still the training after graduation remained.

Now evolved the California trend setting style insofar as Pharmaceutical education was concerned. The initial degree in Pharmacy in most instances became the Doctor of Pharmacy degree. With it came the cry of superiority for such degree holders. With it also came wide expansive trainings, and it is true, acceptance at many levels. Truly, California has become a State to watch—as most truly innovative programs begin there. The acceptance of pharmacists to inject medication, to prescribe drugs, to practice pharmacy as we have known it, in unconventional ways—these have or will have achieved acceptance *first* in California—but may I remind you, despite soft-pedaling to the contrary—these wonderfully trained pharmacists were

(Continued on page 11)

Thanks, Northeastern University

College of Pharmacy
Boston, Massachusetts

These young people recently spent a very full day at Abbott, touching bases in research, development and production.

Many of them were impressed—and said so—with the hundreds of steps and precautions taken to assure a top-quality product.

We were impressed, too—with them.

They were bright, curious, professional and very excited about their careers.

It was a good day. And one way we know of starting—and keeping—a dialogue.

ABBOTT

1083417

PD or NOT PD—PRO—cont.

farmed out to lesser qualified pharmacists to show the neophytes "How it should be done in the real world."

This background presentation is for one purpose only, according to many sources, the applications to schools of Pharmacy are declining; enrollment there is declining; the supply of pharmacists nationally is excessive. My plea is that as we approach the granting of the initial degree in schools of Pharmacy as the "Doctor of Pharmacy" degree by more and more schools, there remains no place for two classes of pharmacists. Unless we utilize the P.D. designation route this is exactly what we will do to strengthen our academic programs and make pharmacy most attractive. We need to maximize its attractiveness.

Please understand me—I am speaking from the heart with nothing to gain by the adoption of any program pro or con. My active days in pharmacy approach a winding down, or end. I have arranged to sell my last drugstore April 1st, so it makes no difference to me personally what you as a profession decide to do.

As one vitally concerned with pharmacy at all levels—and one concerned with fairness, however, it makes every difference to me what you decide.

Personally, I am appalled at the lack of speed with which North Carolina has approached this problem. We have been slow to grasp the general acceptance which the P.D. designation makes possible by its professional acceptance. Let me explain.

Last April at our State Convention I indicated that five states now grant the P.D. designation. Now, however, fifteen states have adopted this designation thus far. Stand back for the ground swell or you will be caught up in it. In the past three years this movement has stimulated these states What does this mean? Well, first of all what it means would have been unnecessary if Dr. Remington's concept had not been inundated educationally. The majority of our practicing pharmacists operate at the wholesale, retail manufacturing or hospital levels. Who should decide name of practitioners—the practitioners, of course. Should we have two classes of pharmacists? That's where we're headed without action by our practitioners.

Should you hold a degree short of Dr. of Pharmacy, M.S. or Ph.D.—without this action—will you be a second rate pharmacist? You know you will. No thinking proprietor who is concerned for the bottom line will hire a B.S. holder who has passed the Board of Pharmacy exams when he can hire a qualified Dr. of Pharmacy who has done the same thing. The public will increasingly demand the services of a "Doctor of Pharmacy."

Just as the optometrists, chiropractors, foot doctors, dentists and medical physicians have done, these practitioners have been identified as doctor.

Case-Western Reserve School of Nursing stole a march on their competitors 4 years ago by awarding their nurses who graduated, the degree, "Doctor of Nursing." Educators administratively now have a degree "Doctor of Education." The administrators in my city and county now are "Doctors."

Physician Extendors—F.N.P.'s and P.A.'s have new stature legally in this State. They can even write Rx's. Never mind that pharmacists must correct their Rx's or call the physicians responsible, if there are questions whether they are on the golf course—or wherever they may be—these folks can legally administer to the public while they enrich the physician by rendering this service. If, as they do—we ever intend to extend health services for the public—we'd better get along with it. We'll never have a better chance or better time to contain costs, make our businesses survive, and secure our profession. Legend Rx products are moving to OTC status in many cases. If we do not move to control these products by serving the public well at the same time—these products will be available at filling stations, food stores and Sunday shops. We as pharmacists have a superior knowledge of drug interactions, and as computers have reinforced this wisdom, we will "hide our light under a bushel" if we ignore this fact.

When my son graduated in Pharmacy, the seniors in Pharmacy were simultaneously given, as were the seniors in Medical School, the same exam in Pharmacology. The Pharmacy seniors outscored the medical school seniors on this examination. Who knows this? Very few I admit but they should! At least one of these. Dr. Kipp Waite calls my son routinely when he has a

(Continued on page 13)

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PD or NOT PD—PRO—cont.

question of drug interaction or actions because of this. They were roommates in their first degree studies and Dr. Waite was Phi Beta Kappa, but Jeff outscored Dr. Waite on this exam!

It will take a period of time for the P. D. designation to take hold and be accepted as second nature, but today is a beginning—and we must face it to survive easily. The acceptance of it, will make it easier to convince lawmakers and doctors of our strength. Just as physicians have been strong as a profession, pharmacists will find it easier to obtain fee increases from lawmakers and third party providers. Doctors will return our calls more promptly, or not keep us waiting. Our patrons will depend upon us even more. Just as the Gallup Poll of last July 27th placed the Pharmacist second barely below the 1st place Clergy and ahead of dentists—then physicians. I feel that the proper use of this designation can move the acceptance of the pharmacist to the #1 position in public confidence.

To dispel confusion, what I seek is the P.D. designation not the Degree Doctor of Pharmacy. Without it, holders of the Dr. of Pharmacy Degree are likely to look upon B.S. or other degrees in Pharmacy as the Ph.D's and in some cases M.S.'s regarded the Pharmacy Doctors—avoid blood-letting within the profession. Without this action present 5 year B.S. in Pharmacy holders will suffer in the years to come as they compete at a disadvantage with Doctors of Pharmacy degree holders. Possibly there could conceivably emerge even a new pharmaceutical organization composed of Doctor of Pharmacy—pharmacists to further widen the gap. We do not need or welcome further diversion. We have enough organizations.

I have visited as a pharmacist speaker in 4 states that have passed the P.D. designation and proudly embraced it. Because of the P.D. designation in Arkansas, they currently enjoy the highest attendance at their State conventions in history. They have embraced continuing education and as pharmacists are hungry for knowledge. The University of Arkansas and the College of the Ozarks institutions have re-issued their diplomas, and all graduates of these institutions in the field of Pharmacy are retroactively granted the Degree "Doctor of Pharmacy."

So, if the North Carolina Pharmaceutical Association wants to increase membership, stimulate attendance at State conventions and continuing education seminars—they have to adopt the P.D. designation. Give our members a shot in the arm. Make them exude pride to be Pharmacists. Now, my friends, you know why I ask you so proudly to reassert yourselves and take this bold, first step in joining Pharmacists of America at the practicing level to assert their right to protect consumers when they practice as Doctor of Pharmacy!

There is no one in the room who doesn't believe his B.S. degree is more demanding and represents more depth than any other B.S. degree from any institution. Isn't it reasonable that the holders of these degrees not be subservient to future graduates of this profession?

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CONGRATULATIONS TO

KEN BURLESON

on the remodelling of the pharmacy in Catawba Memorial Hospital in Hickory. We were pleased to have helped plan and complete this project.

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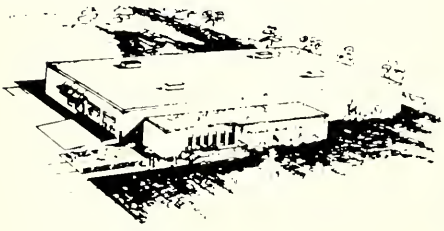

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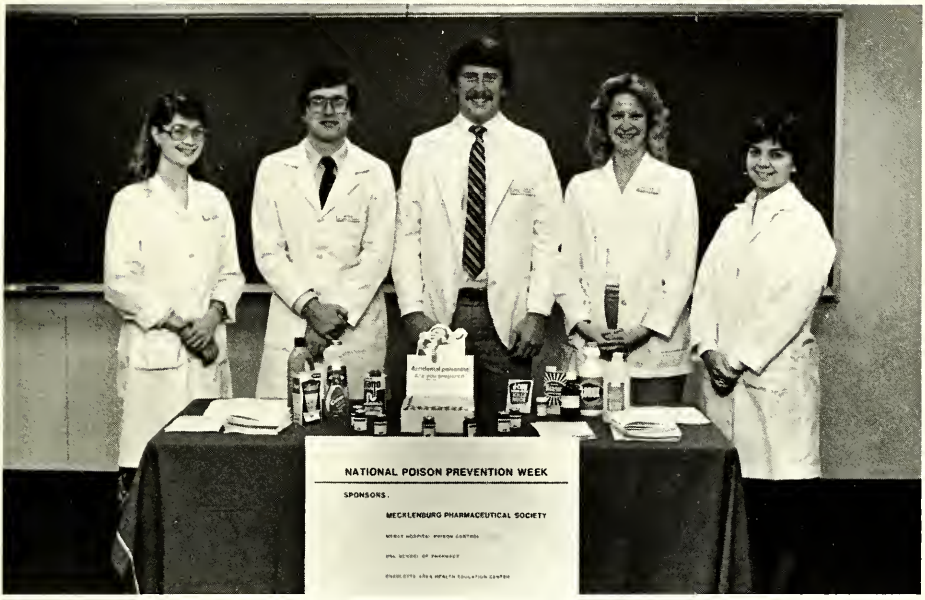

Picture: Senior pharmacy students participating in the Mecklenburg Poison Prevention Campaign: From left, Jean Hesse, Don Helms, Mike Yelverton, Karen Johnson, Carol Muse. Not shown: Hunter Brown, Gail McCaskill.

POISON PREVENTION

Pharmacists in Mecklenburg County recently conducted their fourth annual Poison Prevention Campaign, in observance of National Poison Prevention Week, March 21-27, 1982. Co-sponsored by the Charlotte Area Health Education Center, the Mercy Hospital Poison Control Center, and the Citizen Safety Association, this event is used to distribute free Syrup of Ipecac and safety information to area residents. Bill Evans, President of the Mecklenburg Pharmaceutical Society, and Fran Hemingway, Campaign organizer, coordinated an effort in which over 1000 bottles of Ipecac were distributed through booths in four (4) area shopping malls. The success of the effort was tremendously enhanced by the participation of seven (7) senior students from the UNC School of Pharmacy, on rotation in Charlotte as part of the School's Academic Externship Program.

RABIL FEATURED IN NARD JOURNAL

Ernest J. Rabil, President-elect of the North Carolina Pharmaceutical Association is featured in the March 1982 NARD Journal, in the article "It Keeps Me On My Toes," beginning on page 11. The article chronicles Rabil's entry into the nursing home provider/consultant field and the challenges he encountered.

ROCKINGHAM COUNTY SOCIETY OF PHARMACISTS

1982	President	Joe Estes
	Vice President	Russ Mitchell
	Secretary-Treasurer	Shannon Huff

Rockingham County Society of Pharmacists met at the Margre Restaurant in Eden, Sunday Evening, March 21. President Joe Estes introduced Ann Cox of the Pilot Club who in turn introduced Diane Abbott. Mrs. Abbott gave an informative introduction to the workings of "Lifeline." This is an Annie Penn Hospital based, button operated, alerting system for aid to infirm individuals living alone.

Bill Dudley

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Members—W. R. Adams, Jr., Wilson; Harold V. Day, Spruce Pine; W. Whitaker Moose, Mount Pleasant; W. H. Randall, Lillington; James A. Way, Winston-Salem; David R. Work, Secretary-Treasurer, P. O. Box H, Carrboro, NC 27510

PHARMACY PERMITS

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Belhaven, NC 27810
Ralph E. O'Harrow, Ph-Mgr.

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Emory Milner Watson, Ph-Mgr.

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Locust, NC 28097
Ellison Neal, Ph-Mgr.

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Avondale Pharmacy
2410 Park Road
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Mars Hill, NC 28754
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Asheboro, NC 27203
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P. O. Box 548, US 19, Std. Mall
Maggie Valley, NC 28751
William J. Baldwin, Ph-Mgr.

Issued 1/18/82 T/O
Hoke Drug Co., Inc.
120 N. Main St., P. O. Drawer J
Raeford, NC 28376
Robert M. Wood, Ph-Mgr.

Issued 1/18/82 T/O
Holly Hill Hospital
3019 Falstaff Rd.
Raleigh, NC 27260
Martha H. Vaughn, Ph-Mgr.

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Otis Wayne Creech, Ph-Mgr.

MORE PERMITS ISSUED

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Belhaven, NC 27810
Alton Dale Hardy, Ph-Mgr.

Issued 3/4/82 T/O
Glen R. Frye Hospital
420 N. Center Street
Hickory, NC 28601
George Thomas Winters, Ph-Mgr.

Issued 3/4/82 T/O
Gordon Crowell Hospital
816 S. Aspen Street
Lincolnton, NC 28092
Richard Price, Ph-Mgr.

Issued 3/4/82 T/O
Richmond Memorial Hospital
Hospital Road & Long Drive
Rockingham, NC 28379
George David Teal, Ph-Mgr.

Issued 3/4/81 T/O
Edgecombe General Hospital Pharmacy Dept.
2901 Main Street
Tarboro, NC 27886
C. Foy Bradshaw, Ph-Mgr.

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Herman R. Honeycutt, Ph-Mgr.

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Wilmington Prescription Shoppe, Inc.
107 Castle Street
Wilmington, NC 28401
R. Whitley Bain, Ph-Mgr.

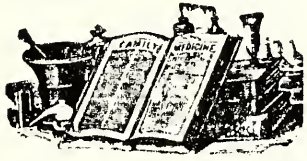
Issued 2/22/82
Wesleyan Arms Pharmacy
1901 North Centennial St.
High Point, NC 27260-3199
Virginia Stancil Brodd, Ph-Mgr.

Issued 1/29/82
The Medicine Shoppe
2022 Asheville Hwy.
Hendersonville, NC 28739
Larry J. Shelton, Ph-Mgr.

Issued 2/1/82
Rx Shoppe, Inc.
5703 East Oak Island Dr.
Long Beach, NC 28461
Mike A. Dente, Ph-Mgr.

Issued 2/2/82 T/O
Statesville Drug Co., Inc.
101 S. Center Street
Statesville, NC 28677
Lynn Waugh, Jr., Ph-Mgr.

Issued 2/2/82 T/O
Medi-Save Pharmacy
105 Doctors Bldg.
Asheville, NC 28801
Jeffrey K. DeWeese, Ph-Mgr.



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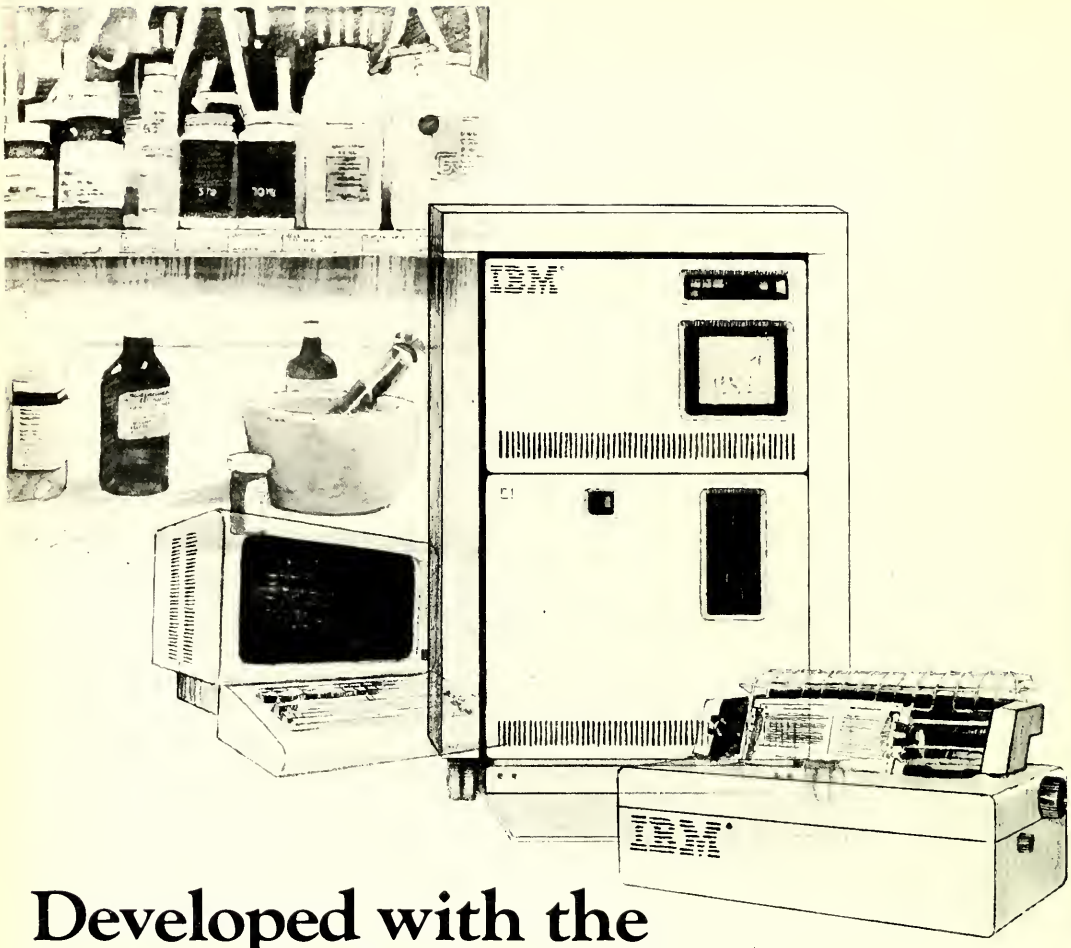
March 16, 1982

NAME	REC.
BARTON, Linda Barbara	PA
BECKER, Stuart M.	NY
BRUISTER, Carroll Lafayette, III	MS
EVANS, James William	GA
FONVILLE, Brenda Hall	GA
FORSSTROM, Paul Raymond	MA
GAGNON, Jean Paul	CT
GALLOWAY, Jennie Sue	IA
HARMAN, John Douglas	WV
HENDRICKS, David Martin	SC
NEIL, Charles Edwin	TN
RINEHART, Perri Moed	SC
ROY, Raymond Albert, Jr.	WV
SAMFORD, Edward Preston, Jr.	VA
SCHAMROTH, Alexander	NY
SORKIN, Eric Steven	NY
SPEARS, Vernon Alexander, Jr.	SC
STONE, Phillip Douglas	VA
SWENBERG, Gwen Elizabeth	MN
UHLER, Thelma	NY
WEGENER, Jennifer Ann	NJ
WILKINS, Raymond Dale	SD
WILSON, Leslie Richard	NY



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NORTH CAROLINA SOCIETY OF HOSPITAL PHARMACISTS

NORTH CAROLINA'S POISON CONTROL CENTERS

Howard M. (Bud) Michael, R.Ph.
(February 7, 1982)
Catawba Memorial Hospital
Hickory, North Carolina

North Carolina's eight poison control centers represent every section of the state and provide valuable emergency drug and poison information to laymen, physicians, pharmacists, and institutions 24 hours every day. All are located in hospitals; four in pharmacy departments.

The poison control center concept began nearly thirty years ago with the opening of the first center in Chicago in late 1953. The burgeoning chemical industry and the widespread availability of a growing variety of pesticides, solvents, and household chemicals mandated the need for reliable poison information. Seventeen centers were operating by 1956 and the need became apparent for a means of coordinating their activities and for a central information processing scheme. In 1957, as a result of the efforts of the centers, pediatricians, and other groups and with the specific recommendation of the American Public Health Association, the National Clearinghouse for Poison Control Centers was established to fulfill this need. The Clearinghouse is now officially the Division of Poison Control of the Food and Drug Administration, U. S. Public Health Service, Department of Health and Human Services.

Until very recently, the division of poison control functioned primarily to collect data from the individual centers (about 80% of the centers consistently reporting) and to gather information from manufacturers and from current literature. This data was abstracted and distributed to the individual centers on 5 x 8 cards specifying ingredients, toxicities, and treatments. In the past year, however, the division has become less involved with data collection and distribution, partly because local centers have, in recent years, largely supplanted the card system with expanded microfiche and computerized data retrieval systems. The mission of the Division of Poison Control is still directed to the reduction in the incidence and severity of poisonings,[1] but the orientation now is toward epidemiological studies and support services.

Direct control over individual centers was never granted to the division. Rather, individual control was left to state health departments or state coordinators. Therefore, no official minimum standards for the establishment, staffing, or operation of poison control centers have ever been issued by the division.[2] (Suggested standards for operation have long been promoted, however, by the American Association of Poison Control Centers.)

By 1960, with nearly 350 centers operating, the Clearinghouse had defined three types of programs:[3]

1. Poison Information Center—functioned solely as a poison information and data collection center
2. Poison Treatment Center—functioned primarily as a treatment center in a hospital emergency room
3. Poison Control Center—combined poison information and treatment center.

Today, about 600 centers operate in the U. S. and its possessions and there has emerged a fourth category—the regional center. A regional poison center is described by the AAPCC[4] as a program covering a specific geopolitical area as large as one or more states and offering five

(Continued on next page)

N.C. Poison Control Centers—cont.

basic services: 1.) a regional poison information service, 2.) a regional treatment service with at least one treatment center, 3.) an educational program for health care providers, 4.) an educational program for the public, and 5.) a regional data collection and reporting system. Although the concept of regionalization has stirred controversy in some sections of the country, its proponents see it as a solution to the lack of standardization and inconsistencies in the quality and quantity of services.

While the poison control centers in North Carolina are regionally distributed, they do not function as a unified network. Each center is essentially community oriented, although those at both Duke and Cone are seen as expanding well beyond their immediate communities.

All eight centers provide 24 hour service and keep written records of all responses. Follow-ups vary, but each center calls back when indicated. The center at New Hanover, for example, calls the patient back on any referral to the emergency room or for any case in which Ipecac is recommended. Duke follows up with a post card within 24-48 hours to elicit responses and provides longer term follow-up when needed. Four of the centers operate from pharmacy departments and utilize the pharmacist as the primary operative (Catawba, Cone, Mercy, and New Hanover). Three are in emergency rooms (Memorial, Mission, Onslow, and Pardee). The center at Duke is a function of the Division of General Pediatrics.

All the centers are primarily reactive, providing poison information in response to telephoned inquiries. The centers in emergency departments probably lean somewhat more toward triage than those in pharmacies. At Pardee, for example, an emergency room staff physician is usually responsible for fielding calls and is often "selective" in providing information to callers, according to a spokesman.

None of the poison control centers receives direct funding from its hospital and only Duke has a paid staff and a specific budget (from long-standing grants). All centers, however, acknowledge indirect financial support from their institutions in the form of facilities, space, departmental budgets, and donated staff time. Several receive some outside funding from grants, contributions, and private gifts. Both Catawba and Cone rely upon their hospitals' auxiliaries for financial aid. The center at Mercy receives assistance from the local United Way.

While each center provides at least occasional speakers and programs, the centers in pharmacies are generally more aggressive in poison prevention campaigns and in marketing their programs through television, radio, and newspapers. Duke offers a variety of programs keyed to specific audiences while Cone has recently subscribed to the National Poison Center Network (Mr. Yuk) and plans a thorough public education program. According to Tim Rice at Cone, "We look at prevention as a major function. Over half our effort is directed to poison prevention programs." Publicizing their center with regular spots on three area television stations has greatly expanded their field of service at Cone. Catawba is establishing a program of activities to deliver prevention education to the 2500 preschoolers in the county's daycare centers. The center at New Hanover has utilized a daily television spot for two years which has been largely responsible for doubling their calls.

A consensus exists among representatives of all the centers that some type of statewide communications network for practitioners at the centers would benefit everyone. Tim Rice notes that, "No one really knows what anybody else is doing." But when it comes to regionalization, the unanimous feeling is one of individual autonomy. Dr. Shirley Osterhout, state coordinator and director of Duke's poison center says, "It would benefit us to have a center to coordinate our activities, but not to supplant the other centers. There are regional differences in poison hazards. People benefit by calling locally first."

Willis Gaines at Mercy recognizes the need for a professional environment but remarks that a regional center, "carries the risk of losing community recognition and may result in watered down educational programs." He further notes that while the centers are well distributed, the populace may not be well covered. "Establishing boundaries for distributing the poison control centers' telephone numbers might assure better service all over the state," he states.

All poison information is obviously not managed solely by the official poison centers. This is evidenced by the availability (and sales) of a variety of poison and drug information systems as

N.C. Poison Control Centers—cont.

well as texts and other references. Most emergency rooms and many pharmacies have at least a fundamental poison information library. Yet, the poison control centers are instrumental in backing up these health professionals by responding to referred calls and by responding directly to inquiries from physicians, pharmacists, and nurses.

The eight poison control centers in North Carolina are:

Western North Carolina Poison Control Center
Memorial Mission Hospital
Asheville (704-255-4490)

Mercy Hospital Poison Control Center
Mercy Hospital
Charlotte (704-379-5827)

Duke Poison Control Center (State Coordinator)
Duke University Medical Center
Durham (919-684-8111) (Toll free 1-800-672-1697)

Triad Poison Center
Moses Cone Memorial Hospital
Greensboro (919-379-4105)

Margaret R. Pardee Hospital Poison Control Center
Margaret R. Pardee Hospital
Hendersonville (704-693-6522 Ext 555, Ext 556)

Unifour Poison Center
Catawba Memorial Hospital
Hickory (704-322-6649)

Onslow Memorial Hospital Poison Control Center
Onslow Memorial Hospital
Jacksonville (919-353-7610)

New Hanover Hospital Poison Control Center
New Hanover Memorial Hospital
Wilmington (919)-343-7046)

[1] Armstrong, George D., National Directions in Poison Control, *American Pharmacy (JAPHA),* NS20: 2 (Feb., 1980), 16-18.

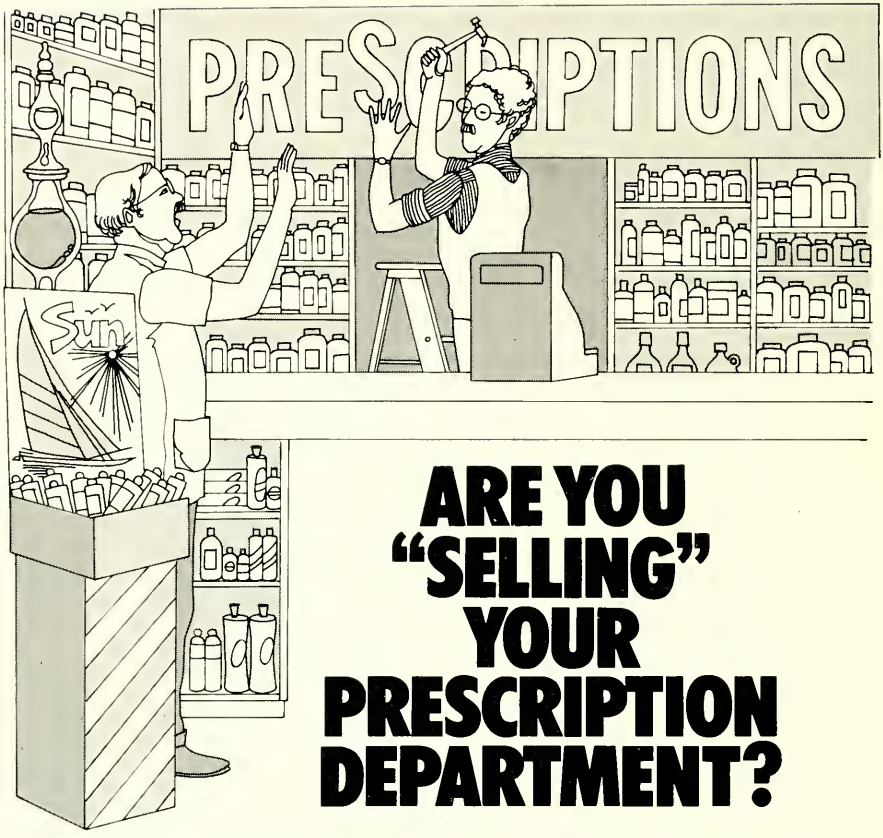
[2] Crotty, John, and George Armstrong, National Clearinghouse for Poison Control Centers, *Clinical Toxicology,* 12: 3 (1978), 303-307.

[3] Simpson, Thomas R., Jr. and Thomas R. Simpson III, Poison Control Revisited, *JAPHA,* NS 16: 12 (Dec., 1976), 659-663.

[4] American Association of Poison Control Centers, Criteria for Regional Poison Control Programs, *Veterinary and Human Toxicology,* 20: 2 (April, 1978), 117-18.

[5] Directory of Poison Control Centers, *National Clearinghouse for Poison Control Centers Bulletin,* 24: 8 (August, 1980).

[6] Comments and opinions of poison control center representatives were taken from a telephone survey of individuals on February 4-5, 1982. Acknowledgement is made for their contribution to this material.



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A SURVEY OF SERVICES OFFERED BY PHARMACIES IN CHARLOTTE/MECKLENBURG COUNTY

J. Keith Caviness,[3] Mark J. Ellison, Pharm. D.[2] and William T. Sawyer, M.S.[1, 3, 4]

[1] The Charlotte Area Health Education Center.
[2] Charlotte Memorial Hospital and Medical Center.
[3] Charlotte, NC, and the Schools of Pharmacy.
[4] Medicine, U. of North Carolina, Chapel Hill, NC.

CORRESPONDENCE: William T. Sawyer, M.S.
Charlotte AHEC
P. O. Box 32861
Charlotte, NC 28232

Introduction

The scope of services offered by pharmacists in community practice in the United States has increased substantially in recent years. Progressive pharmacy practitioners, state and national professional organizations, and schools of pharmacy have provided leadership in advancing the quality of pharmacy practice outside the institutional setting. However, while many pharmacists express philosophical agreement with concepts such as patient medication profiles, emergency prescription services, etc., considerable diversity exists in the quality and quantity of services offered to patients. Unfortunately, quantitative evaluations of community pharmacy services offered in different regions have not been carried out.

Recently, however, a survey was conducted to services offered by pharmacies in a large metropolitan community in North Carolina. This evaluation was carried out by a senior pharmacy student from The UNC School of Pharmacy (JKC), in partial fulfillment of the requirements of the Academic Externship Program, a 15-week experiential learning course offered through the Area Health Education Centers (AHEC) system.

Methods

The survey was conducted in the Charlotte/Mecklenburg County area, a large metropolitan service area in North Carolina, providing an acceptably large data base for such an evaluation. It was carried out over a two-week period in November of 1981, using a 14-question subjective reporting instrument (Table 1.). Written survey questions were mailed to all community pharmacies in the county and a telephone interview was conducted within 10 days thereafter to obtain question responses. Surveys were addressed in all cases to pharmacy managers and questions were answered during the interview by pharmacy managers or their designee. In the case of several large chain stores, survey questions were answered by area managers rather than individual pharmacy practitioners, although spot checks of individual stores were conducted in an attempt to detect variability among stores. For survey purposes, the questions were phrased so as to elicit Yes or No responses. In the case of several questions, additional comments made by respondents were noted in tabularization of the results, as were hours of operation.

For study purposes, community pharmacies were classified as follows: independent pharmacies, small chain pharmacies, or large chain pharmacies. Independent pharmacies were considered to be those with one or two affiliated stores in the service area. Small chain pharmacies were those with three to five stores in the service area, and large chain pharmacies were those with seven or more stores in the study area. In the case of several small chain pharmacies, it was noted that they represented organizations with greater numbers of stores in other states/counties, although they met the requirements of five or fewer facilities in the study area. A total of 34 independent pharmacies were contacted, of whom 33 agreed to participate. Five small chain pharmacy systems, representing seventeen stores, were included, and two large chain pharmacy organizations, with 22 and 15 stores respectively, were surveyed.

(Continued on page 25)

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Pharmacy Survey—cont.

Results and Discussion

Mean hours of service/week were initially computed for each classification of community pharmacy practice. On the average, the number of hours of operation per week were lower for independent pharmacies (62.7) than for small chain stores (73.4) or large chains (79.0). In addition, while all stores in one large chain, and the majority (91%) of stores in the other, gave Sunday business hours, only 33% of independent pharmacies reported Sunday operations.

Responses to the survey questions are summarized in Table 2. Among the three groups of pharmacy sites, there were notable differences in the scope of services offered, as well as the frequency with which they were offered within each classification. For services other than Sunday operations (Question 1), large chain pharmacies responded positively primarily to questions 5 and 12, with one chain responding that it also provided a pediatric discount (no. 13). As a rule surgical supplies and ostomy supplies were not stocked and, because of security considerations, emergency services were not available (with the exception of one store in one large chain open for 24 hour service). Independent pharmacies on the other hand were more variable in services offered, with 17% reporting that delivery service to the immediate vicinity was available and over 50% reporting some kind of patient profile service. Surprising enough, a large number (88%) of independent respondents indicated that they would open their store in the middle of the night for emergency service, although several also indicated that they would require a police escort in doing so. Equally surprising, 88% of independent respondents also indicated that they provide in-store charge accounts for preferred customers. In several cases, it was noted that this was a practice they would continue to provide for established customers but would like to discontinue as soon as possible. No large chain stores and few independents (6%) indicated the availability of ostomy supplies, although one facility did describe itself as a certified distributor of ostomy appliances and accessories. Among surgical supplies, crutches were most often available for sale (42%) or for rent (33%) while wheelchairs and other surgical supplies were not as readily available (18% and 27%, respectively). Although most independent pharmacies indicated that they stocked ingredients necessary for compounding prescriptions and would compound on request, several admitted that they preferred not to engage in compounding and would refer patients on occasion to other facilities.

Results from facilities categorized as small chain stores indicated a diversity of offered services less than that of independent stores, but somewhat greater than that of large chains. The most frequently reported services not related to operating hours were prescription compounding (100%) and senior citizen discounts (53%), similar to practices of large chain organizations. The other most commonly offered services, patient profile-systems (24%), availability of crutches (29%), and emergency prescription services (24%) were all provided less frequently by stores in this group than by independent pharmacies, but more commonly than by chains.

Comment

Obviously, a survey of this type is subject to certain potential methodologic problems. By necessity, the evaluation was confined to a subjective response and it was not possible to objectively verify the accuracy of each answer. However, it is unlikely that respondents would purposefully falsify the information since they were also told that the results of the survey would be made available to all practitioners in the community. In addition, differing interpretation of the questions by different respondents may have contributed to some inconsistency in answers among facilities although the questions were phrased to reduce ambiguity as much as possible. By intent, no survey of pricing techniques or practices was undertaken, since prices are all too often presented as the only consideration in assessing pharmacy services. Similarly, generic substitution practices and the types and quality of generic products employed were not assessed, for many of the same reasons.

The results, nonetheless, provide interesting data on the current state of pharmacy practice in one North Carolina community. It may well serve as a benchmark for assessing changes in pharmacy practice, through follow-up surveys, over the coming years.

(Continued on page 27)

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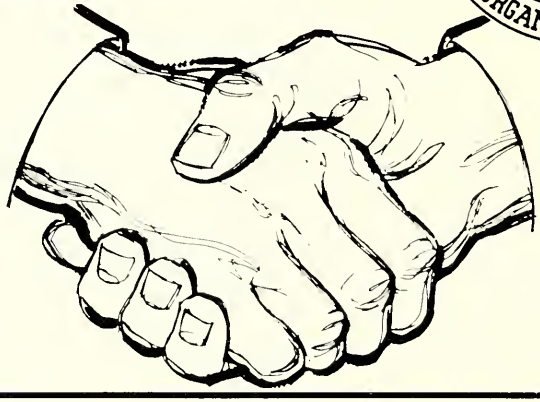

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Pharmacy Survey—cont.

Table 1.
Survey Questions

1. Are you open on Sundays?
2. Are you open 365 days each year?
3. a. Do you offer a delivery service to your vicinity?
   b. If yes, is this service free?
4. Do you provide all of your patients with a patient profile service?
5. Do you have most ingredients that are necessary for compounding prescriptions, and do you fill compounded prescriptions if a patient requests you to do so?
6. Do you sell crutches?
7. Do you rent crutches?
8. Do you sell wheelchairs?
9. Do you have a full line of surgical supplies?
10. Do you have a full line of ostomy appliances and accessories?
11. Would you open your store in the middle of the night if one of your patients needed a prescription filled during an emergency situation?
12. Do you provide your clientele over 65 years old with a 10% discount on prescriptions?
13. Do you provide parents of a child that is four years old or younger a 10% discount on prescriptions?
14. Do you provide in-store charge accounts for preferred customers?

Table 2.
Summary of positive survey responses, by practice site[1]

QUESTION	Independent N = 33	Small Chain N = 17	Large Chain N = 37
1	11 (33)	13 (76)	35 (95)
2	1 (03)	0	2 (05)
3a	23 (70)	3 (18)	0
3b	16 (48)	2 (12)	0
4	17 (52)	4 (24)	0
5	32 (97)	17 (100)	37 (100)
6	14 (42)	5 (29)	0
7	11 (33)	3 (18)	0
8	6 (18)	2 (12)	0
9	9 (27)	3 (18)	0
10	2 (06)	1 (06)	0
11	29 (88)	4 (24)	0
12	22 (67)	9 (53)	37 (100)
13	1 (03)	0	15 (41)
14	29 (88)	4 (24)	0

[1] number of positive responses—percentage positive in parentheses.

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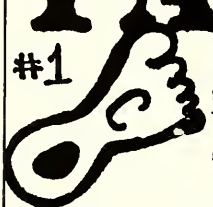

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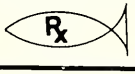

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DEAN'S MESSAGE

"Challenges of Leadership"

Sincere congratulations to the graduates who have labored so hard for commencement day. Generations of graduates have always faced challenges unique to their time; this generation will be no different. With the passage of time, the challenges have become more subtle, requiring a different kind of creativity to resolve them. At the turn of this century one child in ten died in childbirth; in more recent times the scourge of polio touched the lives of thousands. These problems have been largely eliminated by our advancing knowledge and technology.

The great challenge which we face today is to resolve the general problems of leadership, ethics, and morality. Although ethics and morality are predominately personal issues, leadership is often looked upon as coming from an individual or an organization. Today's challenge for our graduates, however, is creative, individual leadership. As someone has said, "We're not going to have a highly productive society (pharmacy profession) unless more people (pharmacists) take responsibility for leadership and do not look for the leader."

I would like to share with our graduates five characteristics of an ideal leader given by Professor Argyris of Harvard: (1) He doesn't blow up when provoked but exhibits a high tolerance for frustration. (2) He encourages others to discuss and pull apart his decisions without feeling his personal worth is being threatened. (3) He understands the rules of competitive warfare and does not feel distressed if a colleague shows a little "fight." (4) He expresses hostility tactfully. (5) He can snap out of defeats without feeling personally shattered and can quickly start thinking of the next goal.

Education should allow us to think rationally and objectively about the issues that confront pharmacy. Pharmacy skills are most effective when they are exercised with leadership and compassion. Out of context, but well worth remembering is what Dr. Glen Seborg (former Chairman of Atomic Energy Commission, Past President of the American Chemical Society, and Nobel laureate) has said—we must avoid having "tyranny of parochial interests."

Dean Tom S. Miya

PHARMACEUTICS DIVISION HAS NEW CHAIRMAN

The School of Pharmacy welcomes Dr. James Swarbrick as Professor and Chairman of the Division of Pharmaceutics. A native of London, England (and a U.S. citizen since 1974), Dr. Swarbrick received his B.Pharm. from London University, his Ph.C. Diploma from the Pharmaceutical Society of Great Britain, his Ph.D. in Pharmaceutics from London University's Faculty of Medicine, and his D.Sc. in Surface and Physical Chemistry from London University. He is a registered pharmacist in U.K.

Dr. Swarbrick's background includes his roles as Professor of Pharmacy and Chairman of the Graduate Education and Research Council at the University of Southern California School of Pharmacy, Dean of the University of London School of Pharmacy, and his position as Director of Product Development at the Sterling-Winthrop Research Institute. Dr. Swarbrick has also served as Professor of Pharmaceutics at the University of Sydney, Australia and as Professor and Chairman of the Pharmaceutics Division of the University of Connecticut School of Pharmacy. In addition, Dr. Swarbrick has taught pharmacy on the faculties of the Purdue University School of Pharmacy and the Chelsea College of London University.

Listed in *American Men and Women of Science, Men of Achievement,* and *Who's Who,* Dr. Swarbrick is the author and co-author of numerous articles, books, and presentations. His current research interests include drug permeation through membranes, properties of interfacial films of pharmaceutical and biological significance, and drug form optimization through formulation.

Dr. Swarbrick currently has a research project funded through industry to look at the permeation of new chemical agents through human skin. The World Health Organization has been supporting his work to develop a once-a-month intramuscular injection of the antileprotic drug, dapsone. This work forms the subject of a patient application.

Dr. Swarbrick now resides in Chapel Hill with his wife, Pamela.

Dr. James Swarbrick

ADDITIONAL FACULTY JOIN SCHOOL OF PHARMACY

Dr. Steven Wyrick

Dr. Steven Wyrick has joined the faculty of the Division of Medicinal Chemistry as Assistant Professor. A native of Greensboro, Dr. Wyrick received his B.S. (Pharmacy) and Ph.D. (Medicinal Chemistry) degrees from the University of North Carolina at Chapel Hill. His experience includes participation in the Chemistry and Life Sciences Group of the Research Triangle Institute and involvement with the Postdoctoral Chemistry Program at the School of Pharmacy's Medicinal Chemistry Division.

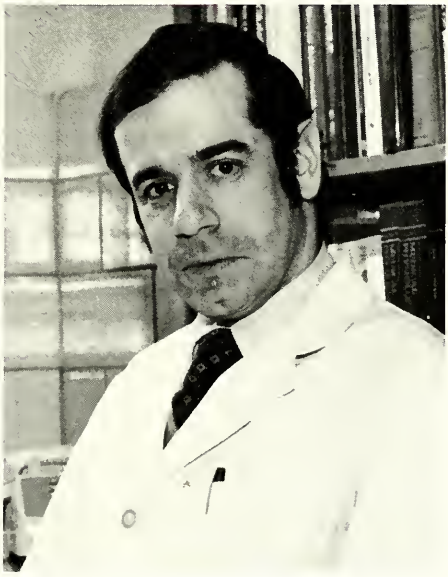
Dr. Wyrick's current research projects are in the areas of synthesis and testing of hypolipidemic indazalones and benzylsulfanamides. He is also interested in the development of anti-tumor agents.

A 1970 N.C. champion in weight-lifting (a sport he still pursues), Dr. Wyrick is also a rock and roll enthusiast. He performs as electric guitar player and vocalist for the band "Marauder" whose music can be heard in Chapel Hill and Durham nightspots.

Dr. James Maguire joined the School of Pharmacy faculty as Assistant Professor in the Division of Medicinal Chemistry and the Curriculum in Toxicology. Born in Kansas, Dr. Maguire received his B.A. (Chemistry) degree from the University of Minnesota and his Ph.D. (Organic Chemistry) degree from the University of North Carolina at Chapel Hill.

Dr. Maguire's background includes a National Institute of Health Postdoctoral Fellowship with the Pharmacology Branch of the National Institute of Environmental Health Sciences and a NIH Fellowship with the University of North Carolina at Chapel Hill's Department of Pharmacology.

Dr. Maguire is interested in the metabolism of hydantoin anti-convulsants and hopes to use such studies in the synthesis of compounds which feature increased duration and fewer side effects. He enjoys sharing his hobbies of sailing, gardening, and photography with his wife, Dr. Louise Ball who also shares his professional interests. (Ms. Ball has her Ph.D. in Biochemistry from the University of London.)



Dr. James Maguire

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ASSISTANT SURGEON GENERAL SPEAKS AT PHARMACY SCHOOL

The UNC-Chapel Hill School of Pharmacy was honored to welcome Rear Admiral Richard Ashbaugh as a Visiting Lecturer on Feburary 22. A graduate of Temple University's School of Pharmacy with a Master of Public Health degree from Tulane University, Mr. Ashbaugh has spent his twenty-one year professional pharmacy career with the United States Public Health Service.

The highlight of Mr. Ashbaugh's visit was his meetings with School of Pharmacy students. Following a luncheon with student body officers, Mr. Ashbaugh addressed the Pharmacy student body on the subject of "The Pharmacist's Role in Today's Public Health Service."

During this first visit to the Tarheel State, Mr. Ashbaugh toured Burroughs Wellcome, the North Carolina Memorial Hospital Pharmacy, and the UNC Schools of Pharmacy and Public Health. He was particularly impressed with the pharmacy in UNC Student Health Services and remarked upon its modern design and innovative approach to the practice of pharmacy.

Rear Admiral Richard Ashbaugh

WITH THE FACULTY

Clinical Instructors PATSY S. HUFF, SANDRA H. HAK, and Associate Professor STEPHEN M. CAIOLA of the Division of Pharmacy Practice have published a paper entitled "Immunizations for International Travel as a Pharmaceutical Service" in Volume 39 of the *American Journal of Hospital Pharmacy*, January 1982;39:90-93.

Assistant Professor ABRAHAM G. HARTZEMA of the Division of Pharmacy Administration has published an article entitled "Self-Medication" in *Pharmacy International*, Vol. 3, No. 2, February 1982, pp. 57-58.

Dean TOM S. MIYA attended the Society of Toxicology meeting in Boston, Massachusetts February 22-25. Dean Miya is past president of the organization and serves as the Chairman of the Task Force on Federal Legislation.

Clinical Assistant Professor STEVEN ALMOND, Associate Professor STEPHEN M. CAIOLA and Clinical Instructor PATSY S. HUFF of the Division of Pharmacy Practice have published an article entitled "Pharmacist-Managed Allergy Desensitization Program" in *American Journal of Hospital Pharmacy* 1982; 39:284-8.

NEW SCHOLARSHIP FUND FORMED

The Roy Burgiss Scholarship Fund has been established under the Endowment Fund of the N.C. Pharmaceutical Research Foundation, Inc. The fund is dedicated in the memory of "Doc" Burgiss, a member of the UNC School of Pharmacy Class of 1925. Roy Burgiss served in the N.C. House of Representatives in 1942 and 1944. He also held the positions of Mayor of Sparta, North Carolina and Chairman of the Alleghany County Board of Education.

Burgiss's son Tom graduated from the UNC School of Pharmacy in 1953. His daughter Patsy Burgiss Sanders and her husband Charles Henry Sanders (who presently reside in Granite Quarry, North Carolina) were graduates of the UNC School of Pharmacy's Class of 1948. Burgiss's granddaughter Sharon Sanders Whitesell is the family's most recent pharmacist. A Charlotte resident, Ms. Whitesell is a member of the UNC School of Pharmacy's Class of 1973.

The School of Pharmacy and the Foundation welcomes any gift or contribution to this scholarship fund in the memory of this great pharmacist and statesman.

DRUG INFORMATION REPORTS
by John Kessler, PharmD.

What is the clinical significance of the reported drug interaction between theophylline and erythromycin? Is a dosage adjustment of theophylline necessary?

In 1976, troleandomycin—a chemically related macrolide antibiotic, was first reported to increase serum theophylline levels when the two drugs were administered together. The average decrease in theophylline clearance was 50% (therefore serum levels increase by at least 50%).

Erythromycin, also used extensively in asthmatic patients, has been reported to increase theophylline levels in select individuals. The various forms of erythromycin (base, stearate, ethyl succinate, or estolate) have all have reported to increase theophylline serum levels (range 11% to 59%). The most plausible mechanism of this interaction is competitive inhibition of enzymatic degradation of theophylline in the liver. Currently, it is not possible to predict in which individuals this interaction will occur. Guidelines have been developed however, which may help predict those individuals where the interaction would be clinically significant. A brief review of theophylline elimination will help to illustrate this point.

Theophylline kinetics are normally described as a linear process. Therefore, changes in dosage or the ability to eliminate theophylline will result in a proportional change in the serum level. Under certain conditions however, theophylline may undergo non-linear kinetics; i.e. small increases in dosage or small decreases in elimination will result in disproportionally larger increases in serum levels. The point at which theophylline kinetics change from linear to non-linear varies with individual patients and is a dose-dependent effect.

The following guidelines are offered for use in consultation with the prescribing physician in the management of this interaction.

In general, patients who are maintained on theophylline with serum levels in the low end of the normal range (10-20mcg/ml) will be less susceptible to toxic effects if erythromycin causes an interaction in that individual. Rather than decrease the theophylline dose, it would be advisable to educate the patient to the toxic effects of theophylline should they occur.

Individuals who are maintained with serum levels in the upper end of the normal range (greater than 15 mcg/ml) are more susceptible to non-linear kinetics and should be monitored closely for toxic effects with dosage adjustments made when appropriate.

HEALTHY AGING IS FOR EVERYONE

The annual student public awareness program at the UNC School of Pharmacy has had another successful year with a project called "Healthy Aging."

The Healthy Aging Program is aimed at helping the elderly with medication problems and also hopes to improve pharmacist-patient relationships within the elderly population. The students achieved their goals by getting Governor Hunt to declare March as Healthy Aging Month and distributing 1,000 packets of information to pharmacists around the state (over 900 packets were hand-delivered during spring break, March 7-13). The packets contained a booklet called, "You and Your Over-the-Counter Medications," which the students designed themselves. They also distributed "Vials of Life" in those countries that have the program. In addition, they prepared radio and TV public service announcements, and many students went into their communities and gave presentations with a local pharmacist. The presentations consisted of a slide show, a question-answer session, and a game to support the slide show. The students are particularly proud that Alamance County has joined the "Vial of Life" program after a student presentation, and three more counties are interested in the program.

If you are interested in the Healthy Aging Program or would like to have a presentation in your community, please contact: "Healthy Aging," Donna Tidwell, Beard Hall 200H, Chapel Hill, NC 27514.

REGIONAL PHARMACEUTICAL SOCIETY MAKES COMMITMENT TO NCPRF

Chester Woodard, President of the Northeastern Carolina Pharmaceutical Society has announced that the NCPS has contributed $100.00 to the North Carolina Pharmaceutical Research Foundation. A resolution has also been passed by the Society guaranteeing future annual contributions of this amount.

The Foundation is especially pleased with the commitment demonstrated by the Northeastern Carolina Pharmaceutical Society. Their dedication to the future of pharmacy in North Carolina is both admirable and appreciated.

CAIOLA MODERATES APHA WORKSHOPS

Stephen M. Caiola, M.S., associate professor of pharmacy practice at the University of North Carolina at Chapel Hill, and L. Peter Bast, Ph.D., director of educational development and assistant professor at the College of Pharmacy at the University of Minnesota, moderated a series of workshops at the annual meeting of the American Pharmaceutical Association which was held on April 24, 1982 in Las Vegas, Nevada.

The series of workshops was jointly sponsored by Roche Laboratories and the American Pharmaceutical Association in an effort to help pharmacists understand and apply various techniques of handling patient education problems commonly encountered in pharmacy practice. The sessions focused on the pharmacist's role as a patient educator and counselor and provided aids for the pharmacist in developing improved communication skills.

Mr. Caiola and Dr. Bast collaborated on the patient education seminars with Dorothy L. Smith, Pharm. D., Director of clinical affairs of the American Pharmaceutical Association; Samuel H. Kalman, director of education, American Pharmaceutical Association, and David R. Harris, manager of pharmacy education and communication development, Roche Laboratories.

Virginia Moore

Virginia Moore has been newly assigned to the Rocky Mount, North Carolina territory to represent Abbott Laboratories, Pharmaceutical Products Division. She has recently completed four weeks of initial training, most of which was spent in Abbott Laboratories' sales training facilities in North Chicago, Illinois. Virginia received her B.S. in Business Management from the University of Wisconsin, and is currently enrolled in the M.B.A. program from Campbell College in North Carolina.

1982 MECKLENBURG PHARMACEUTICAL SOCIETY OFFICERS

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Secretary: Debra Yarbrough
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DEATHS

GEORGE WILLIAM HONEYCUTT

George W. Honeycutt, Rockingham, died at his home Tuesday, March 2, 1982. Co-owner of Federal Pharmacy, Honeycutt retired in 1980 after 32 years. He graduated in 1939 from the UNC School of Pharmacy. He is survived by his wife, Blanche, son, George Jr., and daughter.

MARSHALL LOUIS NEWBERN

Marshall L. Newbern, Wilson, died Friday, February 5, 1982, at the age of 47. He was owner and pharmacist of the Wilson Drug Store. A graduate of the Medical College of South Carolina, Newbern was well-known in Wilson for his work in Scouting. For ten years he had served as scoutmaster of a local troup. He is survived by his wife Gloria and two sons, Marshall and Brian.

THOMAS ROY BURGISS

Thomas Roy Burgiss, Sparta, died Tuesday, March 2, 1982, after several months of declining health. He was a former mayor of Sparta, served two terms in the N. C. House of Representatives and was Alleghany County's first pharmacist. Burgiss was a member of the County Board of Education, and a deacon in the First Baptist Church. He was a past president and honorary life member of the North Carolina Pharmaceutical Association. He served as chairman of the county Democratic party, as coroner and sheriff for two days. Burgiss is survived by his wife Lora, daughter Patsy Sanders of Granite Quarry, and son Tom Reeves Burgiss, Sparta.

QUOTE OF THE MONTH

Surgery, radiotherapy and diagnostic tests are all important, but the ability of health care providers to alter health outcomes depends primarily on drugs. (V. R. Fuchs, 1974, "Who Shall Live?")

MAY IS HIGH BLOOD PRESSURE MONTH

The National High Blood Pressure Education Program has announced the theme for May High Blood Pressure Month as "Be Proud Out Loud," emphasizing the importance of local program's efforts to continue support for HBP education programs.

As states assume increasing responsibility for allocating state and federal funds, community HBP programs will be competing with other health needs for this funding. High Blood Pressure month is an important vehicle for raising awareness about HBP.

The NHBPEP has put together a kit to suggest related activities and offer supporting materials for participants. The kit includes a guidebook," How to Improve Visibility for Your HBP Control Program" and is available in limited quantities by writing High Blood Pressure Information Center, Box IM-I, 120/80 National Institutes of Health, Bethesda, MD 20205.

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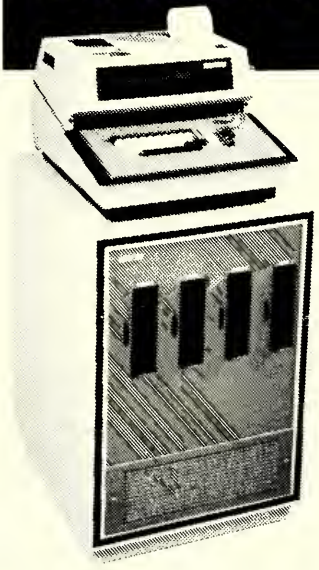

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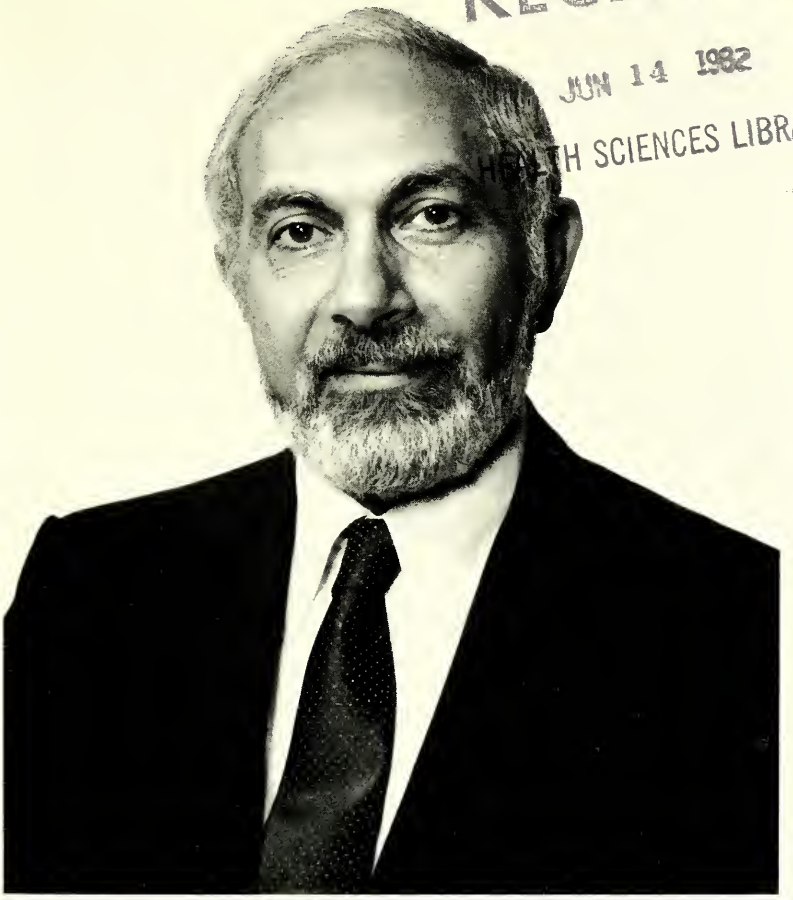

Ernest J. Rabil, President, North Carolina Pharmaceutical Association.

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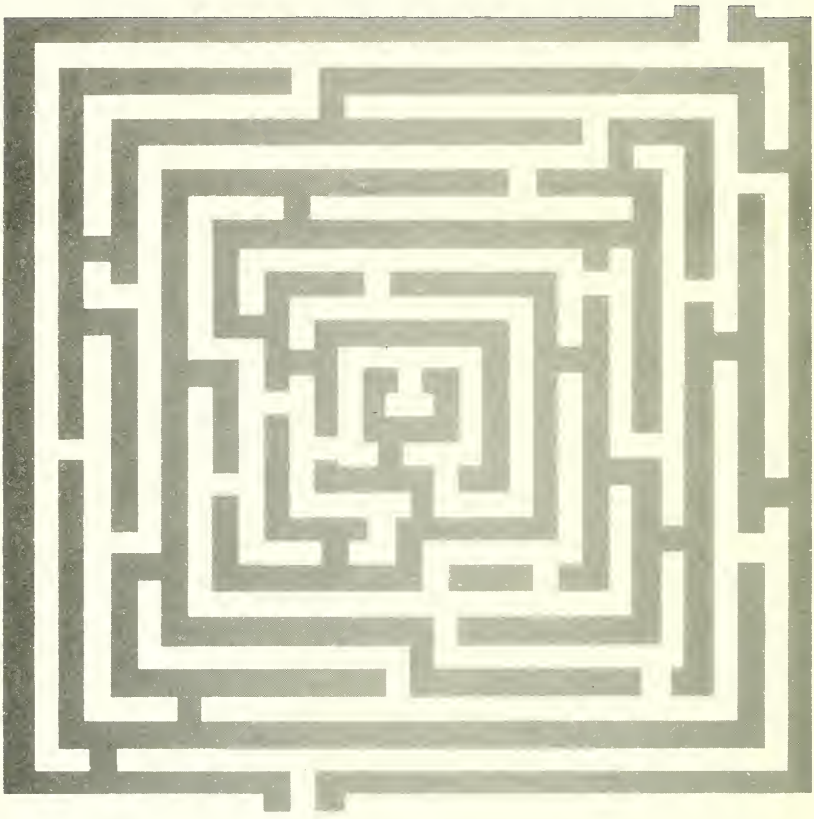
The R&D maze is a long and costly road to travel.



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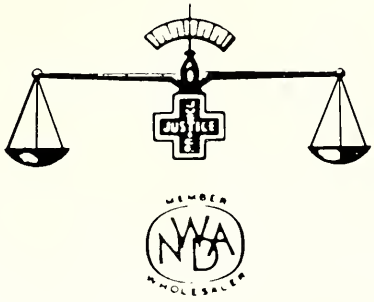

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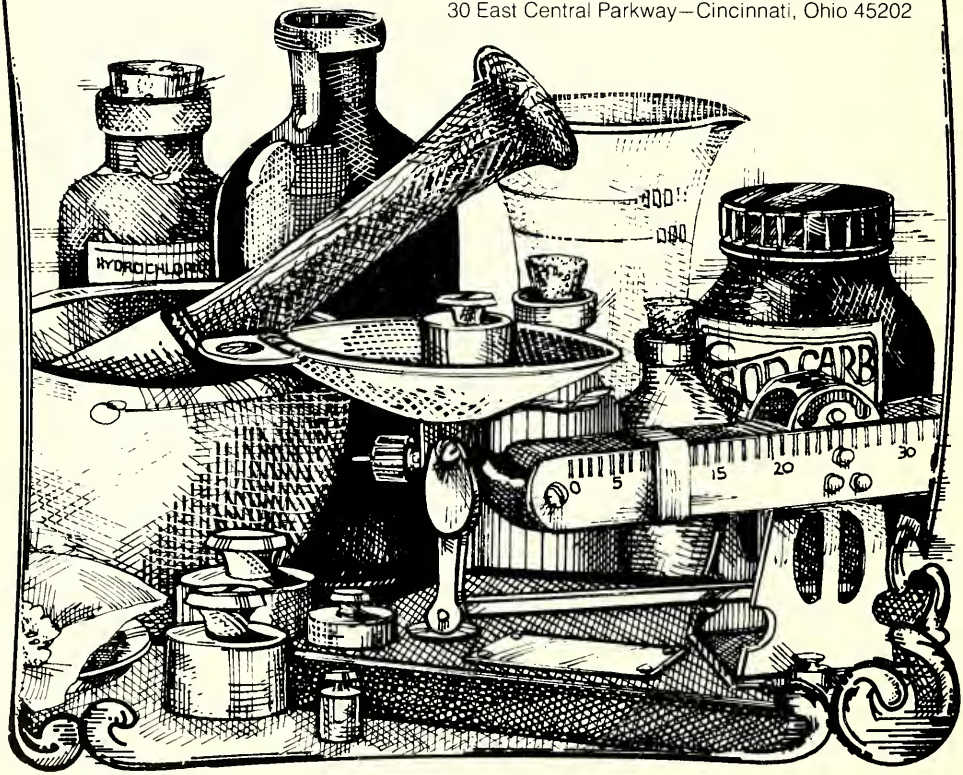

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REPORT TO THE NORTH CAROLINA PHARMACEUTICAL ASSOCIATION

from

The University of North Carolina at Chapel Hill School of Pharmacy

and

The North Carolina Pharmaceutical Research Foundation

April 1982

As we begin the second century of progress in pharmaceutical education at The University of North Carolina at Chapel Hill, there is much for which we are thankful.

Many of you are aware of the first major remodeling this year of Beard Hall since it was occupied in 1959 during the tenure of Dean Brecht. About 700 students, parents, and friends of pharmacy attended the Open House held on January 31. For those of you who did not have the opportunity to attend, please feel free to visit us at any time. The Open House was the first "comprehensive" attempt in recent memory to share with the general public what pharmacy education is all about.

Other significant events occurred. It was a shock to learn of Associate Dean Werley's retirement which took place on January 31st. As Dean, I learned to respect his judgment in student cases and our discussions led to many long-ranging decisions regarding the curriculum as well as other items. I will cherish for many years our working relationship during my five years and one month with "Lee." As most of you know, Dr. George Cocolas was appointed Associate Dean, and I am sure our association will develop as it did with Lee. Dr. Cocolas continues to serve as Chairman of the Division of Medicinal Chemistry as the search to fill this position nears completion. Also retiring on January 31 was Leonard Berlow, Assistant Professor of Pharmacy Administration. His replacement is actively being sought.

Dr. James Swarbrick joined our faculty on December 1 as Chairman of the Division of Pharmaceutics. He comes to us from the University of Southern California and has already made significant contributions to our program. By July 1 or shortly thereafter the School will have almost a dozen new faculty faces as a result of replacement or new positions.

In regards to our faculty, I am pleased to note that during 1980-81 the faculty published 1 book, 1 textbook chapter, 53 refereed articles, 5 general articles, 16 abstracts, and 5 institutional packets. Forty articles are in press. Two patents have been issued, and 6 are pending.

The faculty has also been industrious in seeking extramural funds for their research amounting to $561,500 during 1980-81. This figure does not include unrestricted gifts and certain contracts amounting to over $160,000. It is necessary for us to be more aggressive in obtaining funds since although the above figures may seem large, we have just lost all federal capitation funding amounting to an annualized $250,000 for the last ten years.

The School's Doctor of Pharmacy Program is now in its first year with five students. An additional seven are expected to be enrolled this summer. This program is not funded, and we must be cautious in its expansion so as not to jeopardize the basic degree program.

The School's association with the North Carolina Memorial Hospital and the Medical School continues to flourish. Notable among these relationships is the recent collaboration with the Medical School in the development of the Clinical Pharmacology Program. One of our faculty members will have his research laboratory located in the Medical School which will give our students access to research facilities unavailable in the School of Pharmacy.

The School's collaboration with the Area Health Education Centers and the accomplishments of this collaboration in our instruction, continuing education, and research programs must be a recent-day miracle. At this point in time it has become part and parcel of our program. The School will place greater efforts into maintaining this relationship.

The School of Pharmacy Alumni Association, led by President Frank Lowder, its Board of Directors and able Executive Secretary Mel Chambers, has become in its short life a viable and moving force. Its several meetings have been highly successful. It deserves your membership and your support.

From a Dean's perspective, even with the great fiscal constraints now upon us, I have never been more optimistic of the role pharmacy will play in the health care system and the role the School will play in its development.

Attached to this report are admissions, enrollment, and graduation data. It is presented for your perusal.

North Carolina Pharmaceutical Research Foundation

The North Carolina Pharmaceutical Research Foundation is in its 36th year of operation during which it has made invaluable contributions to the welfare and progress of the School. It continues to do so.

As in past years, the great expenditures from available funds went for the support of our undergraduate students for matching federal loan funds. I view this as a continuing pressing need. Operating expenses, including solicitation expenses, auditor's fees, and fiscal agent fees make up a large part of our expenses and run a close second at about 58% of the expenditures for the scholarship category. The Foundation's expenditures for this category will be reduced with the new fiscal agent. A category which will be increased is Faculty Development, a category which can play a large part in capturing additional extramural funds.

The Board of Directors, four elected by this Association and two by the Board, have worked exceptionally hard this past year. The Finance Committee met several times in Chapel Hill and made important decisions approved by the Executive Committee. One of these was the selection of a new fiscal agent to manage its funds. This has resulted in one of the best short growth periods in our history. An investment policy was established where a long-term annual expenditure from its endowment earnings would not exceed 5%.

Solicitations will be coordinated closely with Carolina Annual Giving (CAG). As most of you know, you can give to the Foundation or the School by designated giving to CAG. Our initial experience would appear to indicate that the system has great potential.

The total assets of the Foundation currently stand at an all-time high and its management is in good hands. The Foundation's growth and its potential for pharmacy development has never been better. An analysis of our solicitation data, however, indicates that only about 6% of our requests result in giving. It is my hope that CAG will be helpful in making an improvement. If ever needed, your University and your School now need your moral and substantive support.

George H. Cocolas,
Associate Dean

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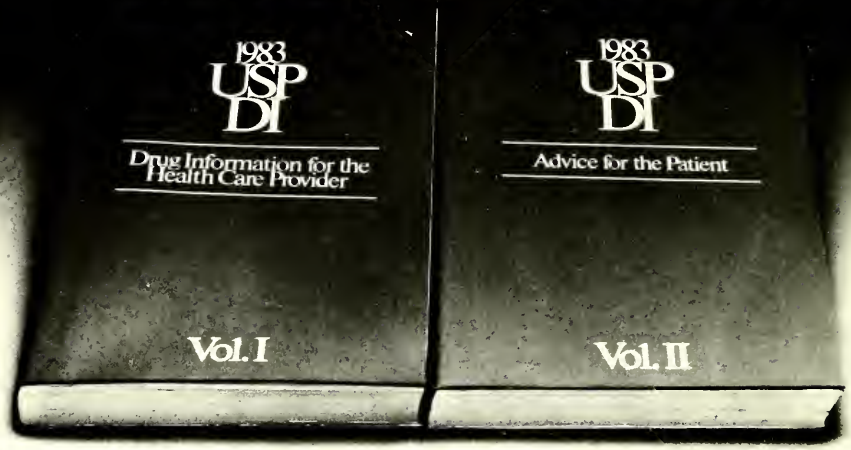

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AXING ENTITLEMENT PROGRAMS

by Leslie Winner

The first phase of President Reagan's new economic policies has caused significant reductions in North Carolina's Medicaid program. Given the escalating cost of health care and the additional cuts which will be implemented by the federal government in subsequent years, North Carolina legislators are faced with a problem of major dimensions. They must either find new ways of funding health care or they must bring spiraling health care costs under control. If they can do neither, a bleak alternative lies ahead: a decrease in health care services for the poor—children, elderly, and others who in fact are North Carolina's "truly needy."

Anticipating the problems ahead for Medicaid, Gov. James B. Hunt., Jr. testified on March 10, 1981, before the U. S. House of Representatives Subcommittee on Health in his capacity as chairman of the Committee on Human Resources of the National Governor's Association (NGA). He pleaded with Congress not to make absolute and insensitive cuts in the Medicaid budget but rather to make substantive reforms in the program which would save as much or more federal dollars:

> We [the NGA] sincerely believe we can offer you an interim solution to the problem of rapidly escalating Medicaid costs without sacrificing essential health care services or denying care to the elderly poor and the needy children of this nation. . . . The need for health care will not disappear along with the dollars to fund it. Soneone will have to meet those needs, and I fear that it will fall to our community and state institutions to care for those people perhaps in a setting or at a level that is both costly and inappropriate, but the only one available to them. My concern, then, is that we reduce Medicaid program costs, but that we do so in a way that will preserve a balanced health care package for our poorest citizens at the least cost to the taxpayer.

Despite Gov. Hunt's statement, and similar pleas by others, Congress took a sizable bite out of the Medicaid program. In the Omnibus Budget Reconciliation Act of 1981, Congress reduced by three percent the portion of the states' Medicaid programs paid for by the federal government for federal fiscal year (FY) 1982, which began on October 1, 1981. This action would then cause North Carolina to lose over the nine affected months of the state FY 82 (October 1981 to June 1982, the end of the state's fiscal year) an estimated $8.7 to $24.6 million in Medicaid funds, depending on the action taken by the General Assembly. And the losses would get larger in future years as the federal percentage declined further (4 percent in federal FY 83 and 4.5 percent in FY 84).

State Budget Crises

This cut hit the state during what was already one of the worst budget crises in years. Revenue estimates were low, the highway funds and transportation budgets were in desperate straits, and there was not enough money to give teachers and other state employees a decent cost of living raise. Given the political difficulty encountered increasing the gasoline tax in the spring of 1981, no legislator wanted to raise other taxes. And because the federal budget cuts affected many programs, Medicaid was competing with other programs for additional appropriations.

Thus, President Reagan and the U. S. Congress had saddled the General Assembly with a sizable problem—one not of its own choosing or making. The N. C. legislature, in its October budget session, had to decide whether to appropriate new *state funds* of some $8.7 million and avoid any reductions in services or to reduce the program and absorb a total cut resulting from *federal actions* of $24.6 million.

The General Assembly did not respond by increasing the state's Medicaid appropriation; instead it limited services, changed reimbursement rates, and limited the number of recipients eligible to participate in the program. In the Medicaid portion of the Appropriations Act,* the legislature included seven provisions, which for the first time:

1) limited the number of physician, clinic, and out-patient visits to 18 per recipient per year, with very few exceptions;

2) limited the number of mental-health clinic visits to 18 per recipient per year;

(continued on page 9)

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Axing Programs

3) limited the number of drug prescriptions to four per recipient per month;

4) eliminated 19 and 20 year-old students from AFDC-related Medicaid coverage;

5) froze reimbursement rates for doctors, optometrists, clinics, and other practitioners at June 30, 1981, payment levels;

6) changed the system for setting hospital reimbursement rates from a cost basis to a flat rate, effective November 1, 1981; and

7) froze the number of authorized new nursing home beds in the state.

These new provisions will cause severe hardships on both Medicaid recipients and other North Carolinians. A person who is dependent on receiving weekly psychiatric help at a mental health clinic, for example, can now make only 18 such visits a year. And if the person denied access to a mental clinic ends up in an institution, the cost to the state will be more than the savings netted by the change in the Medicaid coverage. For another type of hardship, consider the revenues lost from decreased reimbursements for public and nonprofit hospitals. These hospitals must make up the losses in Medicaid reimbursements through either increased rates charged other patients or additional appropriations from the taxpayers or charities supporting the hospital.

What made the state take these dramatic actions instead of other alternatives? Why did doctors, institutions, and recipients let these actions happen? What are the implications of future federal budget cuts and rising health care costs for North Carolina's Medicaid program?

Medicaid Basic Structure

Answering these questions requires first an understanding of the basic structure of Medicaid. A federally regulated, medical assistance program for the poor, Medicaid is paid for by federal, state, and local funds, according to a formula established by Congress. Each year, the Division of Medical Assistance in the Department of Human Resources, which administers Medicaid in North Carolina, estimates what each aspect of the program—from nursing home care to dental needs—will cost. Then, the General Assembly sets the amount for the whole program, according to the projected costs for the upcoming state fiscal year.

Federal law requires the state to provide funds for some services (such as hospital care), but the state has the power to determine the availability of other services (such as dental care). Similarly, some groups of persons (such as those receiving Aid to Families with Dependent Children) automatically receive all Medicaid services, but the state can choose whether to include others (such as Social Security recipients with very high medical bills). Once persons are determined to be eligible for Medicaid, they are guaranteed—i.e., entitled to receive—all the approved services, regardless of cost; that is why Medicaid is called an "entitlement" program. Since the legislature can never know to what extent Medicaid recipients will use their "entitled" benefits during a fiscal year, the General Assembly approves an appropriation which is only an estimate of what the state will spend. The federal government reimburses the state for about two-thirds of its Medicaid costs. Thus, for every dollar the state appropriates and spends of its own money, the federal government matches that with about two more dollars of federal money.

Increased Payments

The move to cut the federal Medicaid budget resulted in part from President Reagan's general effort to balance the federal budget at the expense of social programs and in part because Medicaid is one of the fastest increasing items in both the state and federal budgets. The elderly, who are increasing in number faster than any other segment of the population, account for the largest part of the Medicaid budget. Almost one-third of the program in North Carolina pays for long-term care in nursing homes alone, and this does not include the cost of long-term care for the mentally retarded Medicaid recipients, which is also very expensive. In addition, the reimbursement rates to Medicaid providers—doctors, hospitals, dentists, nursing homes, etc.—are tied to the accelerating rates of health care costs in general.

Faced with a federally-initiated, funding-versus-services crisis, the state had several options. In June, the General Assembly had approved $580.6 million for the total Medicaid budget for state FY 82. This amount included the federal, state, and local share,

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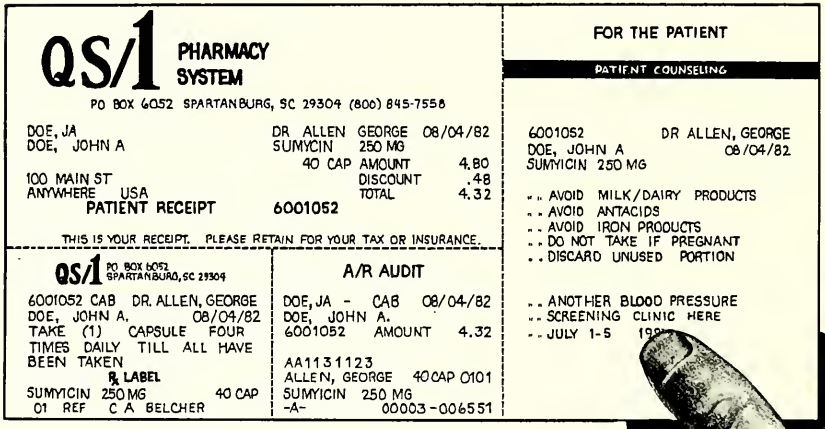

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Axing Programs

and provided the basis from which to compute the federal share of the funds. After the reduction in the federal share, signed into law in August, the General Assembly had three choices. It could:

1) appropriate an additional $8.7 million in state funds and hold the program at its current level of services;

2) vote no additional state money and reduce services by $24.6 million; or

3) vote some additional money and reduce services by an amount less than $24.6 million.

Why did the legislature decide to cut services by an estimated $27.6 million when the state could have kept the loss resulting from federal actions to only $8.7 million?*

Barbara Matula, director of the Division of Medical Assistance for the state, agreed, in an interview for this article, that the legislators had these three options. "But I was not asked as to whether the state could make up [the cuts with] appropriations or absorb the cuts," she said. "The [state] decision was made in the spring. I was asked to present all the possible options to cut costs. At no point did they say to me, 'How much money do we need to bail out the feds?' "

As early as February 1981, Deputy State Budget Officer Marvin Dorman wrote a memorandum to the Lt. Governor, Speaker of the House, and other legislative leaders informing them that Gov. Hunt's position was that "federal cuts cannot be picked up with state funds."

Democrat Position

The Governor's position fit in well with the partisan attitude prevailing in the legislature. The legislative leadership decided that the Democrats in Raleigh would not bail out the Republicans in Washington. As many legislators said in private, "The people need to feel the effect of the Republican cut."

In addition, there was a considerable amount of confusion about exactly what the state had to do to avoid cutting back the Medicaid program. On Thursday of the week-long October session, the legislature was debating the Appropriations Act. The Joint Appropriations Committee had responded to the federal budget cut by recommending the service and reimbursement cuts listed above. For the first time the proposal was presented to the full House of Representatives. One of the recommended cuts—limiting the number of prescriptions available to four per recipient per month—upset some members, and an amendment was offered to change the limitation from four to six.

When the chairman of the House Appropriations Expansion Budget Committee, Rep. Billy Watkins (D-Granville), rose to defend the committee's action on prescription drugs, the confusion about the Medicaid budget cut was apparent, even among the most knowledgeable and powerful of the legislators. A persuasive member of the House leadership, Watkins had to respond on the spur of the moment to an amendment which involved the complex calculations of the Medicaid appropriation. Faced with this immediate and difficult task, he mistakenly said the amendment would cost the state an extra $2.3 million, an amount the legislature would have to delete from some other budget item, if the amendment passed. While the overall cost of increasing the number of prescriptions would have been about $2.3 million, in fact, the state's share would have been only about $800,000. In other words, if the General Assembly appropriated an extra $800,000, the prescription limit could have been increased. The rest would be paid by the federal government. Told that the amendment would cost $2.3 million by the influential Watkins—who even in good faith had his figures wrong—the House defeated the amendment.

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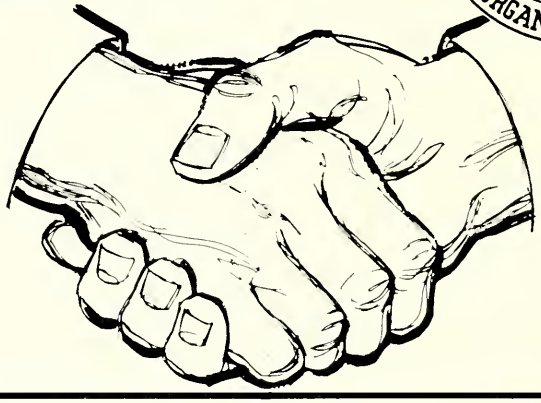

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Representative Watkins' error was typical of the confusion which prevailed. Part of that confusion resulted from the complexity of the Medicaid program, which few legislators other than those involved in the human resources appropriation process understand very well. For example, during a January 1981 meeting of the House Health Committee, the members were debating some amendments to the North Carolina statute affecting Medicaid. One committee member asked quietly what the difference between Medicaid and Medicare is.**

Federal Cap

Contributing to the general lack of knowledge about the program was confusion over an early Reagan proposal for cutting the Medicaid budget. In his initial attack on Medicaid costs, Reagan proposed to limit the growth of the federal reimbursement to five percent per year, a federal "cap" for a program increasing at nearly a 20 percent annual rate. Since Medicaid is an entitlement program, total Medicaid payments cannot be limited; the covered health care treatment of all eligible people must be reimbursed. Consequently, if Reagan's proposed cap had been enacted, the state would have had to pay 100 percent of the cost increases over the federal five-percent ceiling. During the spring 1981 session of the General Assembly, legislators grappled with the question of how to deal with a federal cap if it were enacted by Congress, an action that would have resulted in a loss to North Carolina of some $39 million. Adding the state and local match to the loss would have meant reductions in services of some $58 million. The proposed cap would have absolutely limited federal reimbursement, and anything above that cap would have had to be paid totally out of state and local funds. This proposed cap proved to be politically unacceptable to hospitals, doctors, nursing home operators, and state governments, and Congress rejected it. But the memory of the proposed cap was still fresh in October and added another layer of misunderstanding to the Medicaid debate.

All these sources of confusion contributed substantially to the final Medicaid appropriation that cut services in three areas and reimbursement rates in three others, effectively reducing the program in North Carolina by $27.6 million for the state FY 82, from an estimated $580.6 million to $553.0 million. Few legislators understood that an appropriation of only $8.7 million in state funds would have avoided any cuts in services at all.

In addition to partisanship and confusion, other forces contributed to the legislature's choice of the most drastic option. Legislators saw the Medicaid cuts as a chance to start controlling reimbursements to nursing homes, doctors, and hospitals—the parts of the program that legislators fear are getting out of control. Limiting the cost of inpatient treatment in hospitals and the number of long-term care beds available in nursing homes gave the legislature a foot in the door. Prior to October a combination of federal regulations and political pressure from the health care establishment had prevented the General Assembly from enacting significant controls on health care costs. The threat of even more drastic cuts in future years gave the state new leverage with these groups. Moreover, no significant pressure came from recipients, who are neither well organized nor politically powerful, to protest the limitations on services. Legal Services of North Carolina represented its clients in the October session but had little help from other groups. Since no powerful pro-Medicaid lobby was functioning in October, the legislative leaders were able to make the stringent cuts.

Reduction in Services

But even in cutting services worth $27.6 million, the legislature demonstrated some sensitivity. It chose to reduce services rather than to limit substantially the group of people eligible to receive Medicaid. Those persons receiving Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) must be included in the North Carolina Medicaid program. But the "medically needy"—often retired or disabled persons whose only income is Social Security and whose medical bills are very high—could have been eliminated entirely from the program by the General Assembly but were not.

Under the current federal legislation, the federal share of the formula decreases again next year, even as Medicaid costs keep increasing. In its budget session this June, just

(continued on next page)

Axing Programs

before the state's FY 83 begins on July 1, 1982, the General Assembly must again cope with the federal cuts. If the legislature chooses the same action it did last October—appropriate no additional money to cover the decreasing federal share—services must be reduced by some $48 million, almost twice as much as this year. And the federal reductions could get even worse.

The Secretary of the U. S. Department of Health and Human Services, Richard S. Schweiker, in a recent letter to David A. Stockman, director of the Office of Management and Budget, said that an interagency study group had approved a proposal to finance long-term institutional care, now paid for under Medicaid, through a block grant. If this proposal is accepted by Congress, long-term care would no longer be reimbursed by the federal government as an entitlement service. Instead of the federal government reimbursing the state a percentage of the expenditures for this service, it would appropriate a fixed sum to each state. The effect is the same as a Medicaid cap. The entire amount spent above the federal allocation must be paid for by the state. Thus, if long-term care is placed under a block grant, the state may have to cope with budget cuts for Medicaid services even larger than the currently estimated $48 million.

Cost Cutting Methods

The state has traditionally considered four methods for cutting costs in the Medicaid program:

1) *Limit administrative costs and fraud.* Several minor changes were enacted by the legislature in July 1981, but no one has come up with any way to save substantial amounts by this method.

2) *Limit the services which are covered by Medicaid.* Although eliminating dentures and glasses from coverage probably will not kill anyone, growing old without them is humiliating and painful. Limitations in other services, such as the number of days in the hospital which are compensable, will undoubtedly deprive people of necessary health care or will simply shift the cost to local governments or other patients.

3) *Cut the reimbursement rate paid to Medicaid providers.* This will work only to a limited extent. At some point doctors and hospitals will opt not to participate in the program, risking a separate health care system for the poor. And, to the extent that treatment is provided by county hospitals, clinics, or mental health centers, the lost Medicaid reimbursement must be replaced by county funds. Finally, physicians, nursing homes, and hospitals have powerful lobbyists who will, as a matter of political reality, limit this option.

4) *Limit the group of people eligible to receive Medicaid.* The only group that can be cut is the medically needy, including those people who worked for a living but in retirement have high medicals bills and little income. Depriving them of health care is a drastic measure.

Using a variety of budget mechanisms—from changing eligibility standards to reducing the federal share of a funding formula to considering putting some portions of an entitlement program into a block grant—the Reagan administration and Congress are slowly but surely whittling away those programs on which the poor depend for survival. State officials from throughout the country, even from traditionally conservative areas, have protested these federal actions. In a joint U. S. House Subcommittee field hearing held in Memphis on November 9, 1981, representatives from Mississippi, Tennessee, and Arkansas explained their dilemma as a choice between cutting welfare and Medicaid benefits for the poor or increasing state taxes. And, as the director of the Arkansas Department of Human Services put it: "There is simply no sentiment of any kind for a tax increase."*

If the federal government continues on its current path of eroding basic social programs, then the state will either have to pick up some additional part of the cost or it will have to commence serious efforts to create new cost saving options that do not fit into the traditional list of cost saving solutions.

Last October, the legislature instructed the Division of Medical Assistance to study some dramatic changes in health care delivery to the poor. These included increased home-based and community-based care, prepaid contracts for medical services, and statewide fee schedules for physicians, dentists, and others.

Alternatives such as these must be taken

seriously. Others must be developed. Future cost raising factors must be identified and brought under control early. For example, what effect will the increasing prevalence of for-profit, proprietary hospitals have on Medicaid costs? Changes in health care delivery must be examined before it is too late to influence them.

Unless the state takes the advice Gov. Hunt gave to Congress and breaks out of its traditional mold, it will have only two choices: Appropriate substantially more money for Medicaid or deny necessary health care treatment to people who have no other way to get it.

*Chapter 1127 of the 1981 Session Laws (HB 1392). Section 22.

*The $27.6 million reduction exceeded even the worst option of a $24.6 million cut. Legislative sources attribute this fact to the fear that the original savings estimated for each of the program reductions were too high, and thus the total cuts needed to be higher than the $24.6 million. Also, costs were increasing faster than originally projected, especially for hospitals.

**These two programs have similar origins and names, but they operate in entirely different fashions for very different groups of people. Medicare provides major health care services for people eligible for Social Security, as a private insurance plan does, under a premium/co-payment/deductible system. Medicaid functions as an entitlement program for needy people.

*Joint Field Hearing of the U. S. House Ways and Means Subcommittee on Public Assistance and Unemployment Compensation, House Ways and Means Subcommittee on Oversight, and House Energy and Commerce Subcommittee on Health and the Environment. The chairman of the Public Assistance Subcommittee, Rep. Harold Ford (D-Tn), from Memphis, chaired this hearing.

Special thanks to W. H. King Drug Company for their contribution to the Woman's Auxiliary Convention prizes. Their name was inadvertently omitted from the official convention program.

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1. There's always one more bug.
2. Build a system that even a fool can use, and only a fool will use it.
3. The reliability of machinery is inversely proportional to the number and significance of any persons watching it.
4. It works better if you plug it in.
5. If it jams—force it. If it breaks, it needed replacing anyway.
6. When all else fails, read the instructions.
7. It won't work.
8. If enough data is collected, anything may be proved by statistical methods.
9. When working toward the solution of a problem, it always helps if you know the answer.
10. All great discoveries are made by mistake.
11. The greater the funding, the longer it takes to make the mistake.
12. The progress of science varies inversely with the number of journals published.
13. There's never time to do it right, but there's always time to do it over.
14. The man who can smile when things go wrong has thought of someone he can blame it on.
15. An expert is a person who avoids the small errors while sweeping on to the grand fallacy.
16. Never sleep with anyone crazier than yourself.
17. Men and nations will act rationally when all other possibilities have been exhausted.

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Neil L. Pruitt, R.Ph.
President
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Dorothy L. Smith, Pharm.D.
Director of Clinical Affairs
American Pharmaceutical Association

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Dorothy L. Smith, Pharm.D.

"The type and amount of information required will vary with the specific needs of the patient. But generally, patients want enough information to help them complete the therapy *as easily* and *as safely* as possible.

"Almost all patients will have questions about applying the drug regimen to their own schedules. They are willing to modify their daily activities to accommodate a dosage schedule if they understand why the changes are best for them. But these questions can be answered only on an individual basis.

"Handing the patient a full disclosure sheet does not effectively help 'educate.' In fact, a long list of potential adverse effects may even convince a patient *not* to take the medication.

"Every effort must be made not to frighten the patient. Basically, the role of the pharmacist is to help a patient use drugs most effectively and with the least anxiety."

Reprinted from American Pharmacy, Vol. NS 21, No. 7, p. 382.

John F. Schlegel, Pharm.D., M.S.
Executive Director
American Association of Colleges of Pharmacy

"Most pharmacy professionals recognize the importance of communication skills. Indeed, depending on one's particular perspective, personal pharmacy service that emphasizes patient education can be a source of immense satisfaction, enhanced professional image, increased patronage, and improved health care through better understanding and use of medicines.

"Influences both inside and outside the profession point toward a resurgence of personal contact between the pharmacist and the patient. The public's 'right to know' cannot responsibly be denied. The problem has been in finding time in the pharmacy student's busy curriculum for proper communication skills training.

John F. Schlegel, Pharm.D., M.S.

"For the past several years, colleges of pharmacy have been increasing the quantity and quality of training in this area, and greater attention is being paid to the influence of personality types on professional motivation.

"In the future, the 1980's will likely be described as the 'Communications Era' in pharmacy. The profession has made significant advances, but there is still a need for more change."

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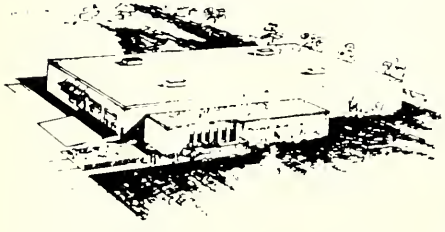

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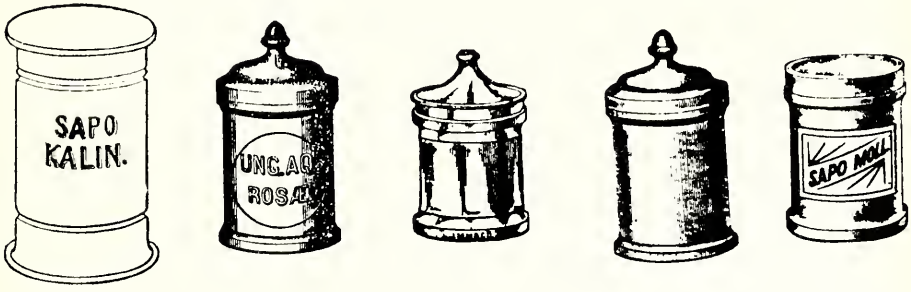

NORTH CAROLINA SOCIETY OF HOSPITAL PHARMACISTS

GERIATRIC PHARMACOLOGY

Karen Oles, Pharm. D., Northwest AHEC Pharmacist

Drug therapy regimens of the elderly are typically extensive, unwieldy and suffer from benign neglect. Patients over age 65 consume over 25 percent of all prescription drugs. The extent of OTC drug use is difficult to quantify. Most elderly live in the community and occupy a significant portion of general medical and surgical wards. Five percent of the geriatric population live in extended care facilities. They receive an average of six to seven drugs per patient; restriction of Medicaid reimbursement to four drugs in North Carolina will probably decrease this average.[1,2]

The aged patient has special pharmacologic needs. Elderly patients have more chronic illnesses and take more medication than younger persons. Consequent to "polypharmacy" there are more adverse effects and drug interactions. While the incidence of untoward effects may not be greater in geriatric patients, more geriatric patients are admitted to hospitals with drug-induced than younger patients. Specific reactions may be more common in the elderly, as is bleeding from heparin or warfarin.[3,4] The elderly do remarkably well considering the large numbers of agents hurled in their direction.

The atypical presentation of disease leads physicians to over-medicate their patients. Physicians are frequently confronted with nonspecific symptoms—dizziness, weakness, psychiatric problems—which can be the only manifestations of serious medical problems. Even the febrile response to a pneumonia may be lost. The benign changes of aging may be confused with a disease process: a sedative-hypnotic is prescribed for the diminished duration and depth of sleep seen with aging when reassurance might do as well. A disease process may be confused with age-related changes: confusion and hallucinations from digoxin toxicity may be regarded as a part of an irreversible senility. In the midst of a diagnostic dilemma drugs are tried. "Prn" drugs and psychotropic drugs for refractory problems habitually pile up in extended care facilities. Physicians and pharmacists need to take a hard look at the identification and achievement of "therapeutic endpoints."[2,3]

It is vital to consider discontinuation of unneeded medication. Antihypertensive drugs, digoxin, and anticonvulsants are frequently used unnecessarily.[5,6,7] It is difficult to select candidates for a trial of discontinuation (see Table 1). One drug at a time should be discontinued and an assiduous follow-up is all important. It is preferable to taper certain drugs. Rapid discontinuation of beta blockers has been reported to cause rebound hypertension and angina. A minor cholinergic rebound syndrome may follow sudden discontinuation of antidepressants and neuroleptics particularly after long-term use. Suddenly stopping benzodiazepine sedative-hypnotics may cause agitation and a withdrawal syndrome including grand mal seizures.[8] The use of drug holidays is without scientific foundation except as regards the antiparkinson agents.[9]

Altered homeostatic mechanisms may cause a loss of the ability to withstand untoward effects of drugs. For example, hyponatremia from thiazide diuretics appears to be more frequent in the elderly due to a defect in free water clearance.[10] Hydrochlorothiazide should be initiated with a 25 mg dose and not increased beyond 50 mg daily for most patients. Postural hypotension from antihypertensive drugs, diuretics, levodopa, neuroleptics and antidepressants are more common in old people.[11] Drug-induced hypothermia and drug-induced dementia are more dramatic in the elderly (see Tables 2 and 3).[12,13]

The sensitivity of drug receptor sites may change with age. For example, it is believed that equivalent concentrations of psychotropic drugs commonly cause more central nervous system

depression in the elderly and must be used in lower doses, but the unbound serum concentrations of drug have not been adequately evaluated.[14] Paradoxical excitation does not appear to increase with age. Resistance to the effects of beta-blockers and beta-stimulants is seen. Vestal[15] found propranolol resistance (indicated by the unbound concentration required to lower the heart beat by 25/min) to increase linearly with age. Similarly, isoproterenol's chronotropic effect is lessened in the elderly. Whether this is due to a decrease in the receptor number, change in the binding affinity of the drug or intracellular mechanisms is unclear. Digoxin-induced reduction in Na-K ATPase activity is more prominent in an elderly person's erythrocytes; "subtherapeutic" digoxin serum concentrations may produce clinically significant inotrophy.[16, 17]

The pharmacokinetic profile of many drugs is modified by the aging process. The altered physiology of the elderly individual may change the absorptive and distributive characteristics and slows the metabolism and renal excretion of drugs. Pharmacokinetics is a relevant science to the prescriber where there is a predictable relationship between the concentration of drug in a body compartment (usually the serum) and the drug effect. This relationship is difficult to prove for some drugs, particularly those with numerous active metabolites. Drug dosing remains both an art and a science.[2, 3]

The major pharmacokinetic processes are drug absorption, distribution, metabolism and renal excretion. Several age-related physiologic changes occur in the gut. Gastric pH increases with age. Gastric emptying time is slowed which delays the absorption of some drugs.[3] Its effect on enteric-coated products might be of significance for bisacodyl (Ducolax), enteric-coated aspirin (such as the usually well-absorbed Ecotrin) and the solid dosage forms of potassium. Oral liquid dosage forms may speed the onset of action and are particularly useful in patients with dysphagia (secondary to a stroke or Parkinson's disease), those requiring feeding tubes, patients with ileostomies or high colostomies, agitated patients and patients who "cheek" their medications.

Generally the quantity of drug absorbed orally is not modified. Prazosin is an exception; its absorption is reduced by approximately one-third in the elderly.[18] Levodopa is thought to have enhanced bioavailability by three to four fold with increasing age.[19] A considerably lower dosage of levodopa for elderly patients should be anticipated.

As a group, the elderly tend to be smaller than young people. They have more body fat (by approximately 35 percent) less muscle mass and less body water.[2] By age 65 the average man has 12 kilograms less lean body weight and the average woman's lean body weight has diminished by 5 kilograms.[3] Many drugs are dosed based on lean body weight.

Serum albumin tends to be reduced in the elderly. Greenblatt[20] showed that patients with normal serum albumin concentrations (4.0 gm/100 ml or greater) decreased progressively from 53.2 percent of those aged less than 40 to 28.1 percent of those aged 80 or older. For drugs that are highly bound to albumin there may be a significant increase in the unbound (active) fraction with age. The Boston Collaborative data showed a 13.3 percent rate of phenytoin adverse reactions in patients with a serum albumin lower than 2.5 gm/100 ml vs a one percent prevalence when serum albumin was 4.0 gm/100 ml or above.[21]

The rate of hepatic artery flow is 1500 ml/min in healthy young people and decreases with age by approximately two percent each decade.[4] Liver mass is also reduced with age. Enzyme function is less active, particularly in the microsomal enzyme system. Enzymes in the cytosol, such as alcohol dehydrogenase, may not be affected by aging.[3, 22] It appears that doses should be reduced in the elderly for theophylline,[23] quinidine, some benzodiazepines, salicylates[24] and possibly some antidepressants.[3, 4]

Liver enzymes can be activated by certain drugs (such as phenytoin) and certain environmental stimuli, notably smoking. The livers of the elderly are less susceptible to the effects of smoking with regard to the metabolism of antipyrine and propranolol.[25] The rate of theophylline metabolism is increased in both young and old smokers.[23] Drugs may also act as inhibitors of microsomal enzyme activity. Examples include chloramphenicol, cimetidine and influenza vaccine.[26, 27] The influence of age on this interaction is unknown.

Unlike metabolism, the effect of age on renal clearance can be quantitated. The creatinine

(continued on page 23)

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Geriatric Pharmacology

clearance, calculated from formulas using age, weight, sex and serum creatinine, provides a clinically useful estimate of renal function. The serum creatinine alone is insufficient since there is a decrease in endogeneous creatinine production with age and the serum creatinine may remain "within normal limits" while the renal clearance of creatinine drops. Both glomerular filtration rate and tubular secretion usually decrease by approximately 40 percent between the ages of 20 and 90. Renal blood flow also diminishes with age and there is a drop-out of functional nephrons.[2, 3, 4] A decrease in renal clearance is clinically applicable for drugs primarily excreted unchanged by the kidney (e.g., penicillins, aminoglycosides, cimetidine[28] and digoxin) and drugs whose active metabolites are predominantly excreted by the kidney (e.g., procainamide and N-acetylprocainamide).[3] This is also important for the treatment of urinary tract infections since antibiotics must achieve an inhibitory concentration in the urine. For example, nitrofurantoin[29] is usually ineffective against E. coli and other gram negative organisms when the creatinine clearance is less than 40 ml/min. Drugs that reduce renal blood flow (some beta-blockers) may not be the preferred choice in patients with low creatinine clearances. Excellent reviews to help the practitioner modify drug dosing at varying degrees of renal insufficiency are available.[30]

Geriatric patients are an unusually heterogeneous population since organ systems age at a variable rate. Bedrest, malnutrition, dehydration, congestive heart failure, thyroid disease and other problems of the elderly may also influence the distribution, metabolism and excretion of drugs.[2, 3, 4] Clinicians should titrate the dose to the individual patient's response and not be swayed too much by population norms. A cookbook approach is not applicable to geriatric medicine and, consequently, recommendations for average doses should be avoided.

The choice of a given drug is usually dependent on its efficacy and side effect spectrum. Changes in pharmacokinetic parameters of drugs are important for choosing a dosing regimen but are rarely a factor in choosing the drug. For example, accumulation of drugs with anticholinergic side effects is not uncommon in the elderly (see Table 5). It should be recognized that an "atropine psychosis" or dementia may be produced without the peripheral warning signals of mydriasis, dry mouth, urinary retention or tachycardia.[1] The neuroleptic or antidepressant with the fewest anticholinergic, sedative and orthostatic properties is considered a "drug of choice" for geriatric patients. Examples are haloperidol (Haldol) and desipramine (Norpramin), respectively. Haloperidol is one of the more common culprits in causing tardive dyskinesia, however, and desipramine will not quickly ameliorate insomnia concomitant with depression as some other agents do. Guanethidine is rarely a choice in the geriatric patient due to its significant orthostasis. Consideration of the patient's other problems or disease states is very important (see Table 4). While there is no agreement on the best second-line agent for hypertension in the geriatric patient, an awareness of the relative contraindications usually provides a rational means to narrow the bewildering choice.[2, 3, 4]

An impeccable therapeutic regimen is all for naught if the patient doesn't take the drug. Medication errors and lack of comprehension of the therapeutic plan are prevalent in elderly patients who care for themselves. Inconvenient dosage regimens may be simplified. For example, antihypertensive drugs can be dosed on a b.i.d. or q.d. regimen rather than t.i.d. or q.i.d. Noncompliance may also result from poor eyesight: the patient cannot read the label, arthritis: the patient cannot manipulate the child-proof vial or handle an inhaler, side effects that the patient won't admit to: "I don't want to blame the doctor" and the prohibitive cost: "But if I buy this drug I won't have enough money for food." An interested pharmacist can uncover these situations, educate the patient and, if necessary, contact other members of the health care team who might remedy the problem.[2]

North Carolina regulations for pharmacist consultants in nursing homes mandate a broad range of activities including recommending rational drug prescribing, monitoring treatment plans and identifying adverse drug effects.[31] The American Pharmaceutical Association's packet to the White House Conference on Aging delineates 11 roles for pharmacists: providing information services and triage to other health professionals and agencies, maintaining drug histories, teaching the elderly about their non-prescription drug use, devices, non-drug

(continued on page 25)

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therapies and drug interactions, and fostering an attitude to maintain the dignity of the elderly and their acceptance of drug therapy as a necessary aspect of aging.[1] Pharmacists should nurture these roles for the sake of the underserved elderly and their own professional futures.

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TABLE 1
PREDICTORS OF
EFFECTIVE DIGOXIN WITHDRAWAL

1. Normal sinus rhythm
2. No history of atrial fibrillation
3. No signs of congestive heart failure
4. Questionable reason for digoxin therapy
5. Digoxin started during pneumonia, anemia, etc.
6. Patient has subtherapeutic digoxin level

TABLE 2
DRUGS POTENTIATING
HYPOTHERMIA

Neuroleptics
Some Antihypertensive agents
Alcohol, CNS depressants
Beta-blockers
Antipyretics

TABLE 3
REVERSIBLE DRUG CAUSES
OF DEMENTIA

Psychoactive drugs
Antiparkinson agents
Diuretics
Antihypertensive agents
Nonsteroidal anti-inflammatory drugs
Quinidine
Anticholinergic agents
Digoxin
Oral hypoglycemics
Narcotics
Corticosteroids
Cimetidine
Anticonvulsants

TABLE 4

CONDITION	DRUG TO BE AVOIDED OR USED WITH CAUTION
Asthma	Beta-blockers
Collagen diseases	Hydralazine
Congestive heart failure	Beta-blockers
Diabetes mellitus	Most diuretics, beta-blockers
Gout	Most diuretics
Hyperkalemia	Spironolactone, triamterene, amiloride
Hypokalemia	Thiazides, furosemide
Liver disease	Methyldopa
Mental depression	Reserpine, beta-blockers
Peptic ulcer	Reserpine
Renal insufficiency	Potassium-sparing diuretics, thiazides

TABLE 5
ANTICHOLINERGIC AGENTS

Neuroleptics—chlorpromazine
Antiparkinson agents—benztropine
Antihistamines—diphenhydramine
Antimotion-sickness drugs—dimenhydrinate
Antidepressants—amitriptyline
GI antispasmodics—belladonna
Preoperative medications—atropine
Sedatives—hydroxyzine
OTC sleeping pills—methyapyrilene
Urinary antispasmodics—probanthine
Disopyramide

NORTHEASTERN CAROLINA PHARMACEUTICAL SOCIETY

The first regular monthly meeting of the Northeastern Carolina Pharmaceutical Society was held on February 25, 1982, at the Holiday Inn in Williamston. The meeting was brought to order by newly elected President Charles Woodard who then introduced the evening's speaker, Dr. Peter Campbell, from the East Carolina School of Medicine in Greenville. Dr. Campbell presented a very informative discussion on "The New Antibiotics."

The society voted to send an annual contribution to the North Carolina Pharmaceutical Research Foundation in memory of four of its past members. We understand this is the only annual pledge at this time.

On April 14, 1982, the Northeastern Carolina Pharmaceutical Society held its second meeting with guest Tom S. Miya and Claude Paoloni of the School of Pharmacy being introduced by President Charles Woodard. Dean Miya gave a very interesting and informative talk about the "New Direction of Pharmacy" and how the School of Pharmacy was attempting to adjust faculty and curriculum to meet the new challenges. Dean Miya assured all members present that the School of Pharmacy at Chapel Hill will continue to provide quality pharmaceutical education and remain one of the top pharmacy schools in the country.

Charles M. Wilson
Secretary/Treasurer

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2. SKF	12. McNeil
3. Roche	13. Abbott
4. Upjohn	14. Dista
5. Parke-Davis	15. Syntex
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7. Wyeth	17. Ciba
8. Pfizer	18. Ortho
9. Lilly	19. Lederle
10. Squibb	20. Schering

PRODUCTS

1. Tagamet (SKF)	11. Ortho-Novum (Ortho)
2. Inderal (Ayerst)	12. Indocin (MSD)
3. Valium (Rochel)	13. Diabinese (Pfizer)
4. Motrin (Upjohn)	14. Persantine (B-I)
5. Dyazide (SKF)	15. Slow-K (Ciba)
6. Keflex (Distal)	16. Lopressor (Geigy)
7. Clinoril (MSD)	17. Tylenol/Cod (McNeil)
8. Aldomet (MSD)	18. Lo/Ovral (Wyeth)
9. Naprosyn (Syntex)	19. Darvocet-N (Lilly)
10. Lasix (Hoechst)	20. Hygroton (USV)

Rankings based on acquisition cost data compiled by Foremost-McKesson's Pharmaceutical Data Services.

GUILFORD COUNTY

The Guilford County Society of Pharmacists held its regular monthly meeting on Tuesday, March 9, 1982 at 8 p.m. in the Kiser Building of Wesley Long Community Hospital. Guest speaker for the evening was Thomas L. Walden, Medical Sciences Liaison for the Upjohn Company. Mr. Walden's discussion of prostaglandins and their potential therapeutic uses was most interesting and informative.

Following the program, a discussion of the Society's participation in the upcoming Poison Prevention Week project of the Triad Poison Center at Cone Hospital Pharmacy was led by President Steve Saxe, and volunteers solicited to help contact all Guilford County pharmacies to insure an adequate supply of Ipecac Syrup on hand.

There being no further business, the meeting was adjourned.

J. Frank Burton, R.Ph.
Secretary

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DEAN'S MESSAGE

COMMENCEMENT NOTES

It is that time of the academic calendar that the traditional congratulations are offered to those who have completed the rigors of academic life. Sincere congratulations to the students and, above all, the parents and loved ones who made it possible.

My fervent hope is that each graduate realizes that graduation is just that, a stepwise progression to your life goals, a time when—for most of you—your life in society commences. Primary to this hope is that you have not been compelled or otherwise been coerced into a profession which you do not enjoy and will not support. All too often we hear about pharmacists' "burn out," emanating from a lack of self-esteem and frustration. The choice, of course, of enjoying your profession and "burning out" is yours. Pharmacy needs every graduate who has the vigor and stamina not only to keep abreast of, but to further the course of pharmacy and to enjoy it. It is a great profession!

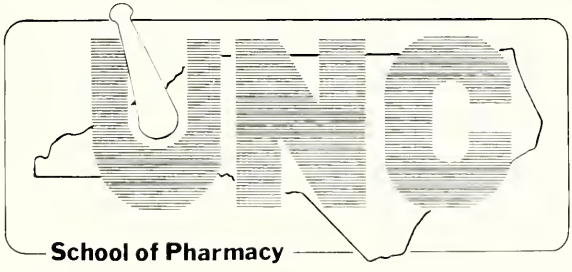
Best wishes to you all.

DISTINGUISHED SERVICE AWARDS

Each year the School of Pharmacy awards an engraved mortar and pestle to an individual other than a student or a member of the faculty who has made outstanding contributions to the instruction, research, and/or service functions of the School of Pharmacy. This year the award is given to two very deserving individuals—George T. Cornwell of Morganton, NC and Howard Q. Ferguson of Randleman, NC.

Mr. Cornwell is a 1934 graduate of the School of Pharmacy. He is the founder, President, Chairman of the Board, and Treasurer of Cornwell Drug Stores, Inc. He is also very active in church and community affairs. Mr. Cornwell recently established the George T. Cornwell Scholarship, to be presented beginning next year to a student in the School of Pharmacy.

Mr. Ferguson is a 1924 graduate of the School. He describes himself as having "been in the drug business for 60 years—since I was 14 years old." He, too, is very active in community and church affairs. Mr. Ferguson is a strong supporter of the NCPhA consolidated Loan Fund and of the North Carolina Pharmaceutical Research Foundation.



Dr. B. Wesley Hadzija
Best Instructor

TOP HONORS FOR HEALTHY AGING

The word has just come in from the American Association of Colleges of Pharmacy, that the Healthy Aging campaign for 1981-82 in North Carolina has just won First Prize in AACP's Public Awareness Competition. Very special congratulations should go to the project's chairman, Donna B. Tidwell, and all the students who were involved in the program. The multi-media campaign on drugs and the elderly reached an estimated 2,000,000 North Carolinians. (A more detailed description of the Healthy Aging project will appear in a later issue of *Script*.)

PHI LAMBDA SIGMA INDUCTION

Three new members were inducted recently into Phi Lambda Sigma, the pharmacy leadership society. The members of the Society are chosen on the basis of outstanding leadership ability in the advancement of the profession of pharmacy and excellence in character. Congratulations to Nancy Lynn Byrd, Susan D. Lee, and Donna B. Tidwell.

HADZIJA NAMED BEST INSTRUCTOR

Dr. B. Wesley-Hadzija, Associate Professor, Division of Pharmaceutics, was honored as Best Instructor at the Annual School of Pharmacy Awards Program.

Dr. Hadzija was selected by the graduating class as the faculty member who has demonstrated the highest qualities of instructional ability based on the following criteria: 1) best presentation of material; 2) most interest in students; 3) fair and relevant quizzes; and 4) most contribution to student's pharmaceutical knowledge.

Her duties at the School include teaching Basic Pharmaceutics, Introduction to Research, and Physical Pharmacy. She also serves as advisor to Phi Lambda Sigma and the Student National American Pharmaceutical Association.

This is the third time that Dr. Hadzija has been honored for her teaching abilities—in 1975 she received the UNC Tanner Award for Excellent and Inspirational Teaching, and in 1979, she also received the Best Instructor Award. This year's graduating class said that they chose Dr. Hadzija for "the sheer genius she exhibited when she lectured, the little note cards, the beautiful organization of concept and detail, the wealth of knowledge that she shared with us . . . as well as her kindness."

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Dr. George Cocolas presenting the Syntex Practitioner-Instructor Award to Frank Hemingway on April 16. Bob Bowers (co-recipient) received his award on April 29.

SYNTEX AWARD

Each year Syntex Laboratories gives an award to the Practitioner-Instructor for outstanding contributions to the Pharmacy Externship Program. Nominations are made by Pharmacy Externs, and the recipient is selected by a committee composed of students and faculty members.

This year, the selection committee gave a double award—to ROBERT BOWERS and to FRANK HEMINGWAY of the Bethel Pharmacy in Bethel, NC. The students felt that both personified the characteristics of excellent Practitioner-Instructors, and that the two gentlemen treated them as professionals first, and as students second. One student stated that they "constantly stimulated students to learn and to do research outside of the pharmacy." She went on to add, "In short, I have nothing but praise for both these men. You can't nominate one without the other."

(Note: This award was first presented at the NCPhA Annual Meeting held in Winston-Salem in early April. It was represented so that the students could see the presentation at the School's Annual Awards Night on April 29.)

QUOTE OF THE MONTH

Surgery, radiotherapy and diagnostic tests are all important, but the ability of health care providers to alter health outcomes depends primarily on drugs. (V. R. Fuchs, 1974, "Who Shall Live?")

DRUG INFORMATION REPORTS

by John Kessler

Drug Interaction: Amiloride and Digoxin

Amiloride is a new potassium-sparing agent with weak diuretic properties, indicated in the prophylaxis and treatment of hypokalemia associated with potassium-wasting diuretics. In patients with congestive heart failure, it is reasonable to predict that amiloride may be administered in combination with digoxin. A study was therefore conducted to determine the effects of amiloride and digoxin when administered together.

Six healthy subjects (ages 21-28) received 0.015 mg/Kg of digoxin intravenously and their individual digoxin kinetics were determined. One week later the subjects received amiloride 5mg twice daily for eight days and digoxin kinetics were again determined. Results show that amiloride increased the percentage of digoxin excreted by the kidneys, and decreased the percentage of digoxin excreted by all other routes (liver, feces, etc.) The overall effect on digoxin excretion was minimal.

Amiloride was shown to abolish completely the positive effect digoxin has on the force of myocardial contraction—also known as inotropism. This effect occurred even in the presence of "high therapeutic" doses of digoxin.

CONCLUSION: Amiloride in a preliminary study in patients with normal kidney and liver function, did not significantly affect the total body elimination of digoxin. Marked changes did occur in the metabolic pathways of digoxin elimination. Amiloride completely eliminated digoxin's effect on the force of cardiac muscle contraction. The clinical significance of this interaction is unknown in patients with compromised kidney, liver and cardiac function. Until additional data are available, patients receiving both drugs should be monitored for alterations in digoxin effect.

NOTE: Amiloride is continued in MIDAMOR® and MODURETIC® TABLETS FROM Merck-Sharp-Dohme.

REFERENCE: Waldorff S. Hansen B. Kjaergard H et al. Amiloride-induced changes in digoxin dynamics and kinetics: abolition of digoxin-induced inotropism with amiloride. *Clin Pharmacol Therap.* 1981; 30: 172-176.

CONGRATULATIONS GRADUATES!

The School of Pharmacy honored its graduates in a ceremony at Hill Hall on Sunday, May 16, 1982. Including the August and December graduates, the total number of graduates is 159. Ernest J. Rabil of Winston-Salem, President of the N. C. Pharmaceutical Association, was the featured speaker.

The following is a list of the May graduates and their hometowns. This is the fifth year in a row that women students constitute the majority of the graduates.

CANDIDATES FOR B.S. IN PHARMACY DEGREE, MAY 16, 1982

RANDALL KENNETH ABSHER, Greensboro
JENNIFER ELAINE ADAMS, Fuquay-Varina
LINA YOUSEF ADHAM, Raleigh
GINGER QUAY ALEXANDER, High Point
RANDALL BRENT ANGEL, King
RITCHIE MURDOCK APPLEWHITE, Snow Hill
PAUL SAUNDERS ASHWORTH, Cary
MARTHA ANNE AULD, Baton Rouge, LA
JAN ELIZABETH BALL, Garner
BETSY RUTH BARNES, Roanoke Rapids
MAHLON DWIGHT BARRINGER, JR., Clemmons
JOE JACKSON BASS, JR., Faison
BETSY ANN BELL, Lumberton
JOSEPH T. BELL, Pembroke
MARTHA WEST BENNETT, Farmville
LORENA PAIGE BLACKMAN, High Point
ALAN FENNER BOYD, Durham
BRIAN KEITH BREWER, Laurinburg
RUTH ANNE BROOKSHIRE, Asheville
HUNTER CREECH BROWN, Tarboro
MARY ELLA BROWN, Gibsonville
TERRENCE VANLOREN BURROUGHS, Raleigh
CAROLYN SUE CALVERLEY, Raleigh
LAURA BANNER CARRINGER, Chapel Hill
ELIZABETH RENEE CAULEY, Clayton
JAMES KEITH CAVINESS, Bennett
CATHERINE JANE CHITTY, New Bern
SUSAN LAZELLE CLELLAND, Fayetteville
ROBERT BRENT CLEVENGER, Washington
RALPH DALTON CLINE, JR., Gastonia
JERREL WOOD COBB, JR., Garner
TAMMY FAYE COBLE, Climax
WILLIAM WALTER COPPEDGE, Durham
CARROLL ANNA CREW, Raleigh
GARY MARK DAVIS, Lexington
SUSAN RHEA DECKER, Greensboro
MICHAEL EUGENE DOWNING, Wilmington
WILLIAM GREGORY DOZIER, Williamston
JANA LUANN DURHAM, Thomasville
CHARLES EDWARD EARNHARDT, IV, Winston-Salem
KENNETH ROGER EPPS, Fayetteville
MEGAN LEIGH FAUGHT, Long Beach
PAGE HARDISON FEUDALE, Cary
BETTY MELISSA FLOWERS, Plymouth
DAVID SCOTT FOSTER, Winston-Salem
JANET LEIGH FOWLER, Charlotte
STEPHEN RICHARDS FURR, Greensboro
JOSEPH RICHMOND GALLOWAY, JR., Supply
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HUGH DAN HARDY, JR., Seven Springs
GLORIA ELAINE HARGETT, Cove City
CYNTHIA LYNN HARTMANN, Oneida, NY
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ADMIRAL GRIFFITH HOWELL, JR., Goldsboro
JAMIE BLYTHE HUFF, Durham
ALTON DALE JOHNSON, Denton
KAREN ELIZABETH JOHNSON, New Bern
SUSAN HALLIDAY JOHNSON, Asheville
BARBARA ANN JONES, Raeford
CHERYL DENISE KENDRICK, Greensboro
GORDON McDONALD KING, Winston-Salem
MARVIN GRAY KIRBY, JR., Tobaccoville
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OLEN CLYDE NAYLOR, Plymouth
DAVID VAN OWENS, Fayetteville
ERIC McFEE PARKER, Candler
RONALD McKINNON PARKER, Hamlet
JAMES FINLEY PERKINS, Brevard
GARY JOE PHILLIPS, Angier
TAMARA PRAZMA, Chapel Hill
BRIAN EDWIN RICHARD, Maiden
WILLIAM HAYES RICHARDSON, JR., Greensboro
KENNETH BART RIDDICK, Aulander
MELANY ANN ROGERS, Plano, TX
DAVID JULIUS ROTH, Saddle River, NJ
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LINDA CAROL WINSHIP, Belleville, NJ
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DARIA ANN WUYCIK, Chapel Hill
MICHAEL PRESTON YELVERTON, Charlotte
KATHERINE MARY ZOBEL, Cary

Rho Chi Initiates at the UNC School of Pharmacy Awards program, April 19, 1982.

1982 AWARD WINNERS

Congratulations to the following award winners. These awards were presented at the Annual Awards Ceremony held April 29, 1982 at Burroughs Wellcome Co. in the Research Triangle Park.

CARROLL ANN CREW of Raleigh, North Carolina received the **Upjohn Achievement Award** in recognition of her performance of outstanding services to the School of Pharmacy. She is a fifth year pharmacy student. MS. CREW also received the **Kappa Epsilon Award** in recognition of her outstanding qualities of leadership, character, service, and scholarship.

GARY MARK DAVIS of Lexington, North Carolina was the recipient of the **Bristol Award** in recognition of his noteworthy achievement in pharmacy. He is a fifth year pharmacy student.

JANET FOWLER of Charlotte, North Carolina was the recipient of the **Merck Award** in recognition of her noteworthy achievement in the profession of pharmacy. She is a fifth year pharmacy student.

BARBARA HAIGHT of Newton, North Carolina was honored with the **NcNeil Mortar and Pestle Award** for her outstanding performance in Pharmacy Administration Studies. Ms. Haight is a fourth year pharmacy student.

JEAN HESSE of Burgaw, North Carolina was the recipient of the **Smith Kline and French Award** in recognition of her academic excellence with demonstrated ability to apply this expertise to clinical practice. She is a fifth year pharmacy student.

BAIN HICKMAN, JR. of Durham, North Carolina was the recipient of the **Rho Chi First Year Award** for his having attained the highest scholastic average in his class for the first year of the Pharmacy curriculum. He is a fourth year pharmacy student.

LINDA HOLLOWELL of Edenton, North Carolina was honored with the **Division of Pharmacy Practice Achievement Award** in recognition of her demonstration of a high degree of professional motivation and concern about the role of the pharmacist in the delivery of health care. MS. HOLLOWELL is a fifth year pharmacy student. She was also the recipient of the **S.A.Ph.A. Certificate** in recognition of her outstanding services to the Student Chapter of the American Pharmaceutical Association. MS. HOLLOWELL also received the **Merck Award** in recognition of her noteworthy achievement in pharmacy.

ALTON JOHNSON of Denton, North Carolina was the recipient of the **M. L. Jacobs Award** in recognition of his demonstration of excellence in Medicinal Chemistry Studies. He is a fifth year pharmacy student. He also received the **Buxton Williams Hunter Award** in recognition of his excellence in campus citizenship and scholarship. (This year, the forty-fifth anniversary of its first presentation, the Buxton William Hunter Award was presented by the first recipient of this award, W. J. SMITH, Former Executive Secretary of the NCPhA.) MR. JOHNSON also received the **Pharmacy Student Body Award** in recognition of his demonstration of the highest qualities of character, deportment, scholarship, participation in extracurricular activities and promise of future distinction in the profession of pharmacy.

SUSAN LEE of Fairview, North Carolina was the recipient of the **McKesson and Robbins Award** in recognition of her service as President of the American and North Carolina Student Pharmaceutical Association. She is a fourth year pharmacy student.

JOHN McCALL of Charlotte, North Carolina was the recipient of the **Fonnie Jackson Andrews Award** in recognition of his positive attitude toward and significant contributions to the profession of pharmacy. He is a fourth year pharmacy student. This fifteen hundred dollar award was made possible by a trust established through the North Carolina Pharmaceutical Research Foundation by Mr. F. J. Andrews, a 1915 alumnus now living in Baltimore.

ERIC PARKER of Candler, North Carolina received the **Pharmacy Faculty Award** and **Lemmon Award** in recognition of his attainment of the highest scholastic average in his class during the three years of professional study. He is a fifth year pharmacy student. MR. PARKER also received the **Student Body President Award** in recognition of his service as President of the student body of the School of Pharmacy.

SUSAN SPEIR of Raleigh, North Carolina was the recipient of the **Lilly Achievement Award** in recognition of her superior scholastic and professional achievement. She is a fifth year pharmacy student.

LINDA C. WINSHIP of Belleville, New Jersey was the recipient of the **Merck Award** for her noteworthy achievement in the profession of pharmacy. She is a fifth year pharmacy student.

INFLATION

PRODUCER PRICE INDEX for April shows inflation catching up with ethical pharmaceuticals. These items rose 2.7% in a month, compared to 0.1% for all items. But using 1967 as 100, ethicals still stand at 169.3, compared to all items at 268.2.

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Claude U. Paoloni, Associate Professor
Director—Pharmacy AHEC Program
UNC School of Pharmacy
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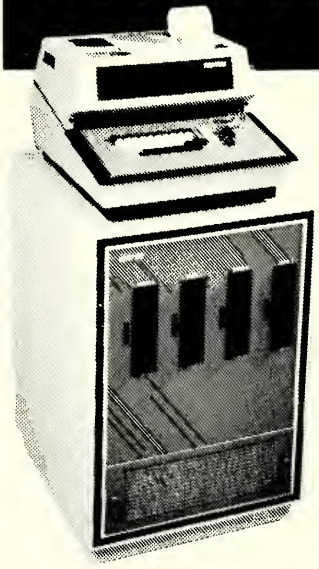

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Eugene W. Hackney, right, is presented the A. H. Robins' Bowl of Hygeia Award, by Michael E. Winters, Manager, Carolina Division, A. H. Robins, at the 102nd Annual Convention of the NCPhA, held in Winston-Salem, April 4, 5, 6, 7, 1982. Photo by Colorcraft.

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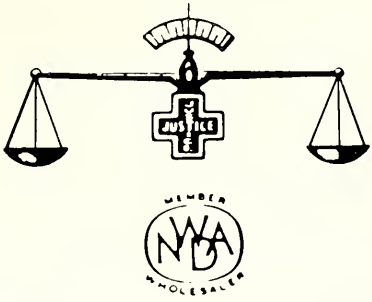

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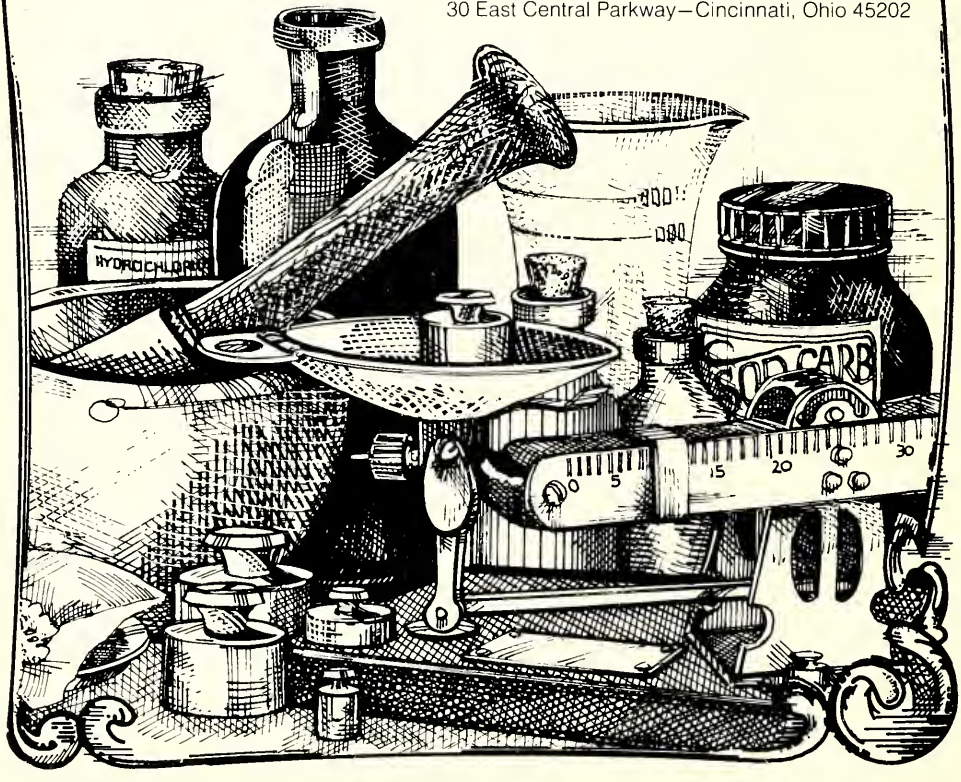

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NORTH CAROLINA PHARMACEUTICAL ASSOCIATION COMMITTEE ON NATIONAL LEGISLATION REPORT

WINSTON-SALEM, NORTH CAROLINA
APRIL 6, 1982

MEMBERS
Chairman, George Hager, Chapel Hill
Jerry Brunson, Dunwoody, Georgia
Jesse Pike, Concord
Seymour Holt, Indianapolis, Indiana
Milton Skolaut, Chapel Hill
Jim Bicket, Durham
Bill Edmondson, Durham
Al Mebane, Chapel Hill

The Association's Committee on National Legislation was appointed by President J. Marshall Sasser in September, 1981. It consisted of Gerald N. Brunson, W. James Bicket, William H. Edmondson, W. Seymour Holt, Jesse M. Pike, Milton W. Skolaut, and George P. Hager (Chairman). The work of the Committee was aided grneatly by Al H. Mebane, III (Ex Officio) and by persons providing expert consultative services: Clealand F. Baker, Chester J. Cavallito, and William F. Pillow (with his associates, James Gorrell and Douglas Cocks).

The first session (evening of February 4, 1982) was an informal dinner meeting of the Committee with President Sasser for refinement of the agenda. Following breakfast at the Institute of Pharmacy, the Committee convened for a very busy second session throughout the day on February 5th.

FEDERAL BUDGET RECONCILIATION—IMPACT ON PHARMACY.—Dr. Edmondson and Mr. Skolaut lead a discussion of a number of budgetary matters of concern to pharmacists including: *Medicaid competitive bidding, Medicare block grants, Medicaid capitation, prudent purchase of drugs (PPOD) plans and volume purchase (VPP) plans,* and *total management of Medicaid by the Federal Government.* An excellent compilation of materials relevant to these topics was prepared in advance by Dr. Edmondson and is on file at the Institute of Pharmacy.

At the meeting, Dr. Edmondson presented an overview on Medicaid competitive bidding, Medicare block grants, Medicaid capitation in the prudent purchasing of drugs plans. Additional issues discussed in connection with PPOD were central warehousing and double standard of pricing and hidden cost in distribution at the state level with PPOD programs. Mr. Brunson outlined a proposal on Medicaid involving VPP, PPOD, and central procurement. It is possible that all programs could eventually fall into one federal program with separate depots called Federal Facilities. The effects on the pharmacy profession, the pharmaceutical industry, and consumers would be considerable and pharmacists should be more concerned about Medicaid and the distribution of drugs within the Medicaid system. The federal government could be moving toward a federal formulary and an expanded MAC program. Mr. Skolaut also discussed the implications of total management of Medicaid by the federal government. A takeover of Medicaid by the federal government could involve a federal compendium, the MAC program, patient package inserts (PPI's), and unit dose dispensing. Concern was expressed about utilization of non-pharmacists in government depots as in the VA hospitals and the military hospitals. Concern was also expressed about a possibility that hospitals would be selected to dispense the drugs in the federal programs and that the cost of drugs to those pharmacies would be cut.

The Committee recommended that the following resolution be considered by the Committee on Resolutions and by the Association:

Whereas, the citizens of North Carolina deserve to have the best medical care available at reasonable cost and accessibility, and

Whereas, President Reagan's budget cuts affecting the quality and services of Medicaid and Medicare could have dramatic effects on the delivery of quality health care products and services in North Carolina, and

Whereas, the North Carolina Pharmaceutical Association's primary interest is in the delivery of quality health care services and products, and

Whereas, the North Carolina Medical Society's interest is in delivering quality health care services to North Carolina citizens,

Resolved, that the North Carolina Pharmaceutical Association should immediately approach the Medical Society of North Carolina to assure that both organizations continue to provide quality health care services and medical care in Medicare and Medicaid programs growing out of President Reagan's new federalism.

DRUG LAG AND DRUG INNOVATION (EXPEDITING THE APPROVAL PROCESS).—The Committee's discussion of this very timely subject was led by Dr. Cavallito and Mr. Brunson and was based on excellent reviews provided by Mr. Pillow dealing with the *legislative implications of the work of the Commission on Federal Drug Approval Process* and with *GAO drug lag findings and appropriate legislation.* These reviews are on file at the Institute of Pharmacy. It was evident to the Committee that postmarketing surveillance (PMS) of newly introduced drugs and drug products could become a major factor in expediting the approval process and that an effective PMS program would depend in large measure on the participation of pharmacists. Accordingly, the Committee recommended the following resolution for consideration by the Committee on Resolutions and the Association's membership:

Whereas, postmarketing surveillance (PMS) of newly introduced drugs and drug products can and should be a major factor in their clinical use with appropriate assurance of efficacy and safety, and

Whereas, PMS can and should expedite the approval process through which new drugs and drug products are made available for post-NDA clinical application, and

Whereas, the pharmacist's participation is essential for PMS activities for the welfare of the public and, at the same time, promotes the pharmacist's clinical role and enhances perception of the pharmacist's importance in safe and effective pharmacotherapy,

Resolved, that the North Carolina Pharmaceutical Association and its members affirm their earnest desire to participate in every possible way in PMS planning with greatest diligence and reliability, and

Further resolved, that the North Carolina Pharmaceutical Association undertake immediately the intraprofessional and interprofessional activities that are appropriate for the participation of North Carolina pharmacists in a well-designed PMS system.

In connection with this same general subject (Drug Lag and Drug Innovation), *new drug applications* (NAD's), *abbreviated new drug applications* (ANDA's), and *paper NDA's* were discussed. The discussion was led by Dr. Cavallito and the following resolution was recommended for consideration by the Committee on Resolutions and by the Association's membership:

Whereas, in the interest of public health, the pharmacist's concern about the adequacy of evidence submitted in support of an ANDA (including a paper NDA) is fully justified, and

Whereas, there is good reason for particular concern about the adequacy of the evidence based primarily on publications growing out of experience with another manufacturer's product,

Resolved by the North Carolina Pharmaceutical Association, that a drug product introduced by a manufacturer under an ANDA (including a paper NDA) must, for approval, be supported by a minimum of actual clinical evidence that the specific manufacturer's product performs therapeutically in a manner equivalent to the approved drug product upon which the published evidence cited is based.

THE "LOOK-ALIKE" ISSUE.—The discussion, led by Dr. Edmondson, was based on a very comprehensive review that was prepared in advance by Mr. Pillow. The Committee was concerned with the *proprietary aspects, clinical aspects, and economic aspects of the color, shape, and size of dosage forms.* The adjudication of the Ives case in the Supreme Court can be

(Continued on Page 7)

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References: 1. Open Coll Survey, *Am Druggist*, Sept 1981 2. Data on file, Burroughs Wellcome Co

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National Legislation

expected to have a considerable effect on the "look-alike" issue. The Ive's case was reviewed by Mr. Pillow and his associates, as follows.

"The Supreme Court has agreed to hear a case decided by the Second Circuit Court of Appeals in favor of Ives Laboratories, in which the Count found six generic manufacturers of look-alike copies of Ives Cyclospasmol® guilty of contributory infringement and enjoined them from continuing to produce or distribute the look-alike tablets. The PMA, the American Academy of Family Physicians and Medicine in the Public Interest each have filed amicus curiae briefs joining Ives; the Department of Justice has joined the generic firms.

"The Circuit Court ruled that the generic companies induced pharmacists to substitute their less expensive look-alike products for Cyclospasmol® and to label the look-alike as the Ives product. This inducement is a violation of the Lanham Act which makes it unlawful for any person to use 'in commerce any reproduction, counterfeit, copy or colorable imitation of a registered mark in connection with sale . . . of any goods or services on or in connection with such use which was likely to cause confusion, or to cause mistake, or to deceive.' The generic manufacturers and wholesalers argued that the illegal representation of generic cyclandelate as Cyclospasmol® was a result of confusion, not of deliberate inducement by them. They made several arguments as to why the cyclandelate tablets should be allowed to continue to be packaged like Cyclospasmol®, in blue and red (400 mg) and blue (200 mg) tablets in spite of this confusion, stating that patients experience anxiety and confusion and may take the substitute medication incorrectly because it is different in shape or color from the original, patented Cyclospasmol®. They also stated that having all manufacturers package any single drug entity in the same size, shape and color tablet would aid doctors in communicating with patients about their medication and aid in identifying what medication a patient has taken in an emergency or overdose situation. Neither of these arguments was substantiated to the satisfaction of the court. They concluded that the generic cyclandelate manufacturers were deliberately attempting to create a situation in which generic cyclandelate could be substituted by a pharmacist for Cyclospasmol® at a lower cost to him without a clear understanding on the patient's part that he was receiving a different product.

"The Supreme Court's decision to review this case was a defeat for Ives because it reopens the case to reinterpretation; however, as PMA points out in its brief, the Second Court decision is based only upon the above-quoted section of the Lanham Act—the most commonly used sections invoked in look-alike cases are those dealing with false designation of the origin of products or with false representation. The Court's impending decision, not yet made (as of January 22, 1982), will not decide the 'look-alike' matter either completely or conclusively, but it may indicate a precedent for look-alike cases of the future."

FEDERAL LAW FOR BURGLARIES AND DIVERSION OF CONTROLLED SUBSTANCES—This item was discussed by Mr. Bicket and Mr. Pike. The Committee reiterated its recommendation of last year that "the Executive Director of the N.C.Ph.A. should be authorized by the Association as promptly as possible to request the members of the North Carolina Congressional Delegation to support appropriate legislation to deter robberies involving controlled substances that are committed to the local level." The Committee also recommended that copies or reprints of articles dealing with this matter be sent to the State's congressmen. As a further step, North Carolina pharmacists—especially those who have been victims of crimes involving pharmacies and/or controlled substances—should now communicate with the representative of their district to discuss their experience and to urge appropriate legislation. The Committee also recommended that Mr. Mebane communicate with other state pharmaceutical association executives urging them to take actions similar to the above in their own states.

THE PRESCRIBING ROLE OF THE PHARMACIST—The discussion of this important issue was led by Mr. Mebane. The concept of "Pharmacist Prescribing" is being considered in several states, with differing degrees of activity. In Iowa, those pharmacists participating in the Capitation Medicaid study, were allowed to practice therapeutic substitution" as a part of this program in an attempt to curtail costs. This program was recently discontinued because of a shortage of funds.

(continued next page)

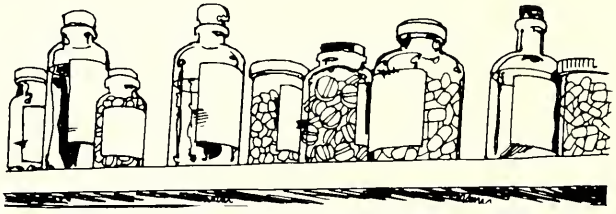
National Legislation

In California, tests sites in clinical settings were established in which pharmacists were allowed to prescribe drugs under certain conditions. A recent study indicated the pharmacist prescribing was more rational than certain groups of physicians under the same settings.

In Washington State, pharmacists are allowed to prescribe legend medications through prescriptive authority. All pharmacists are eligible for this authority and must make application through and receive approval from the Board of Pharmacy. The pharmacist works under protocol of a physician, and within specific guidelines developed by the physician based on his scope of practice.

The North Carolina approach will be to develop an expanded "third class" of drugs which may be dispensed by pharmacists without an externally generated prescription. This "third class" would include those drug products which are for symptomatic relief of self-limiting illnesses, and could be expected to be placed on the OTC list someday.

The Committee is most grateful to Mr. and Mrs. Mebane and members of the staff of the Institute of Pharmacy not only for their diligent efforts in arranging the meeting of the Committee but, as well, for their cordial hospitality that made the work of the Committee a very enjoyable experience.



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ARE YOU AND YOUR PHARMACY READY FOR A ROBBERY?

from April 1982 Pharmacy Practice

Robberies, both armed and unarmed, of pharmacists for controlled substances are becoming increasingly frequent and pharmacists would do well to be prepared for such an event before it occurs. Prior planning can increase the safety of all individuals involved in the robbery and also assist in apprehending the criminal. Police authorities advise specific actions on what to do *BEFORE, DURING AND IMMEDIATELY AFTER an armed robbery.* Dennis Smith, Chairman of the Section on Practice Management, has faced a hold-up man's gun before, and suggests pharmacy managers familiarize themselves and their employees on how to react during an armed robbery.

Before A Robbery: Take a "security inventory" of the pharmacy, both inside and out to deny any obvious "opportunities" for crime. Make sure the pharmacy area is well lit and is clearly visible from the street. If you display poster signs in the front windows put them up high so they don't block vision into the pharmacy. Install some type of security alarm system. Just seeing the foil tape on the windows will discourage robbers from a "security conscious" pharmacy. Invite your local police crime prevention officer to come to the pharmacy and check things out. It's free!

Instruct ALL employees on how to react to a gunman in the pharmacy. Instruct employees on the use of the alarm system. Hold training and discussion periods on pharmacy security so everyone knows their part. Periodically stage a "mock" hold-up to familiarize all employees with proper procedures.

During A Robbery: 1. Take no action that would jeopardize your personnel's or customer's safety.

2. If the robber displays a firearm, or even tells you he's got a weapon, consider him to be armed and dangerous.

3. Activate the alarm, if possible, with safety. *Don't make any fast, obvious movements* toward an alarm button.

4. Follow the robber's directions, but do NOT volunteer.

5. Give the robber only what he asks for.

6. If the robber has a written note, place it out of the reach of the robber, if possible, and save it for evidence.

7. Give the robber only the amount of money he demands. Keep the amount of cash and controlled substances at a minimum to discourage crime.

8. For your own safety be sure to tell the robber your every movement, BEFORE you make them. For example, don't reach under the counter for a paper bag to put the "loot" in without first telling the robber what you are going to do and why.

Immediately After A Robbery: 1. Call the police. Give exact time of robber's departure, direction of exit, get away car description and license number.

2. Lock all doors if possible. This keeps robbers from coming back into the pharmacy and keeps witnesses present until the police arrive.

3. Protect the scene of the crime. Do not touch anything in the area of the crime and keep others away.

4. Jot down the description(s) of the robber(s) and do not "compare notes" with others until you give your information to police. Note as complete a description as possible including race, age, height, sex, facial characteristics, clothing, physical carriage, speech, scars, weapon, etc.

5. Assist the police in every way possible.

6. Inform your state board of pharmacy and the Drug Enforcement Administration of the robbery and submit the appropriate controlled substances loss forms to them.

7. Review your pharmacy's security program and analyze what can be done to improve your program to prevent future robberies.

ANTIPYRETICS AND REYE SYNDROME

The Committee on Infectious Diseases of the American Academy of Pediatrics recommends not using any antipyretic medications to treat children with influenza or chicken pox because of the possible association between such drugs and Reye Syndrome.

The committee questions whether fever control medications should be given when symptoms of these two diseases arise. Alternatives, such as increased fluid intake or sponging with tepid water should be considered, according to the report in the June issue of the AAP journal. Its consensus was that there is a high probability the administration of aspirin contributes to the causation of Reye Syndrome.

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1982 PharmPAC CONVENTION

The Annual Convention of the North Carolina Pharmacy Political Action Committee was held at the Hyatt House in Winston-Salem on Sunday, April 4, 1982. The meeting was called to order at 2:00 by Chairman Rowland Strickland. After the Invocation the Chairman gave a short welcome.

The minutes of the last meeting were approved, and the Secretary-Treasurer's report was given (359 members and $5588.70). The secretary also reported that the Tax Exempt Status was in its final stages.

Ernest Rabil gave an update on the Medicaid Lawsuit and explained where contributions could be sent to help with the legal fees. Mr. Mebane told of the Bills of concern in the upcoming session of the legislature.

1) HB1050—The Revised Pharmacy Practice Ad.
2) HB1300—The Medicaid Fee Bill.

The Chairman reminded the convention that 1982 is an election year and urged pharmacists to get involved in local elections.

The guest speaker for the convention was Representative Margaret Hayden of Sparta. Representative Hayden gave a talk on "Effective Positive Lobbying by a Pharmacist" and told us ways to accomplish this. She told us to get involved with campaigns, to place calls to our legislators, to visit our legislators, to inform our legislators on issues that involve pharmacy and make our views known. She also recommended supporting groups such as PharmPAC.

The last item on the program was a resolution (enclosed) to be presented to the NCPhA Convention.

Resolution No. 18.
Short Title: Hiring Professional Lobbyist From N. C. PharmPAC

WHEREAS, the lobby efforts of the NCPhA have been less than adequate in the past several sessions of the N. C. Legislature, and

WHEREAS, the interest of pharmacy in N. C. can better be served by a professional lobbyists who will be in the legislature on a full-time basis while in session, and

WHEREAS, several independent lobbyist have expressed an interest in fulfilling these duties, and

WHEREAS, issues of vital importance to pharmacy are forthcoming in the next few sessions, where distribution of shrinking state revenues could dramatically affect reimbursement for pharmaceutical services and where the N. C. Practice of Pharmacy Act is still waiting to be adopted.

BE IT RESOLVED THAT $10.00 from the dues paid by each member of the NCPhA be allocated for the purpose of retaining a professional lobbyist and covering the expenses of the Association lobbying effort,

FURTHER BE IT RESOLVED THAT this allocation of funds go into effect on January 1, 1983.

A MESSAGE FROM THE CHAIRMAN

"WE NEED A LOBBYIST," is the opinion stated by the majority of convention-goers in Winston-Salem. We very most likely do need a lobbyist, and the NCPhA probably will engage one in the near future. HOWEVER, the hiring of a lobbyist is not going to ease your political responsibility one iota. Some have the idea that just because we have a person roaming the legislative building, we can rest easy at night and know that all's well in Raleigh . . . OH CONTRARE!! CONTRARE!!

As tired as you may be of hearing NC PHARMPAC officers say this, here it is one more time. *GET TO KNOW YOUR LEGISLATORS NOW;* we may need you to talk to them right before or during the legislative session—and that's not the time to get acquainted.

Secretary-Treasurer Henry Smith reports that NC PHARMPAC has had good responses from any of you regarding the yearly contribution increase from $10 to $25. This is for the rest of you: Don't fail us now! We need your support to broaden our sphere of influence.

In the coming weeks, newly installed NCPhA president Ernie Rabil will be canvassing NCPhA members for their preference of committee assignments. If you want involvement in the NCPhA, please respond to him and work as hard as you can on whatever committee you are assigned.

Rowland Strickland, Chairman

CONGRATULATIONS TO

ED THOMAS

on opening his new pharmacy, Seashore Pharmacy, in Calabash. We are pleased and proud to have helped Ed in the execution and completion of this project.

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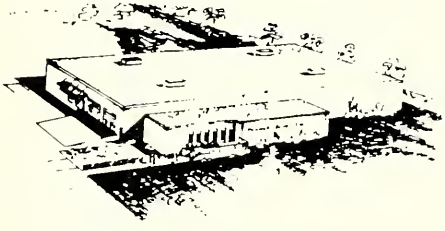

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REPORT FROM THE PRESIDENT OF THE STUDENT BRANCH

Presented by President Susan D. Lee at the 102nd Annual Convention of the NCPhA, Winston-Salem, April 4-6, 1982.

This past year the Student Branch began with its first official meeting on July 19, 1981. It was a meeting of the old and new SAPhA officers which was held at the Institute of Pharmacy. At this meeting we made several plans for the 1981-82 year concerning Fund-Raisers and projects. To start off the school year SAPhA helped with orientation of the new 3/5 class. At this time we stated our membership drive, by the end of the drive we had a record membership of over 300 students. To welcome returning and new students back to school, SAPhA held its Annual Fall Picnic. This year we were able to provide a band along with the usual hamburgers, hotdogs and beer which were enjoyed by both students and faculty.

At our monthly Fall meetings Joe Graedon, Al Rosman, and Marshall Sasser spoke to our members concerning issues in pharmacy. Also, in the Fall, Mary Dorsey, SAPhA Vice-President, and I, attended the SAPhA Midyear Meeting in Charleston, South Carolina. At this meeting Mary was elected to Region III Midyear Meeting Coordinator. The meeting will be held in Chapel Hill this November. As a professional project, SAPhA conducted a Hypertension Screening Clinic in September. Our Fall Semester was completed by a kidnapping of Past Associate Dean Leroy Werley by the "Beard Revolutionary Army" to raise money for a trip to Las Vegas. This money supplemented money raised from various bakesales, breakfasts, and lunches sponsored by the SAPhA members throughout the Fall.

Spring Semester began with my attendance of the APhA Policy Committee on Professional Affairs in Washington, DC. I was appointed to this committee as a student member. Our Spring Speakers were Ernest Rabil, Patsy Huff, and Tom Walden. We conducted a Diabetes Screening Clinic in late February which was well received by the students and the community. In continuation of our Fund-Raising attempts, the Alumni Association, upon our request, greatfully donated money for our Las Vegas trip. With their donation we raised enough money to send six students to the APhA National Convention in Las Vegas in late April. These six students include this past year's five officers and the SAPhA President of 1980. We will be staying at the Alladin Hotel where the meetings will be held.

This year the school-wide project, sponsored by SAPhA was Healthy Aging. Many students have worked very hard on this project and it has been submitted to American Associations of College's of Pharmacy for national competition. As you know the past two projects have won first and second places respectively. This year's project we hope will also be a winner. There has been positive reaction concerning this project from across the state, and regardless of National Competition, this project was a huge success to the School of Pharmacy. Several counties have started or wish to start the Vial of Life program because of our influence in their communities through Healthy Aging.

We wish to thank the Woman's Auxiliary of the NCPhA for their effort in helping us institute the Vial of Life Program for our project.

This year overall has been a busy, yet productive year. New officers have just been elected and will be installed at the April meeting. As President of SAPhA I have enjoyed working with the student body and also meeting with a great many people who have been very helpful to myself and SAPhA. I hope that the upcoming year for SAPhA will be even more successful than this past year. And I will continue to support the new officers in their effort to make 1982-83 another great year for the organization.

1977 CLASS REUNION

The class of '77 from the School of Pharmacy of the University of North Carolina at Chapel Hill is planning to hold their Five Year Reunion in conjunction with the School of Pharmacy Alumni Association meeting, Saturday, September 25, 1982.

Keep atuned, information is arriving soon!

STATE BOARD OF PHARMACY

Members—W. R. Adams, Jr., Wilson; Harold V. Day, Spruce Pine; W. Whitaker Moose, Mount Pleasant; W. H. Randall, Lillington; Joseph B. Roberts, III, Gastonia; James A. Way, Winston-Salem; David R. Work, Secretary-Treasurer, P. O. Box H, Carrboro, NC 27510

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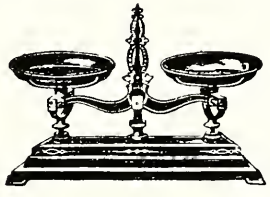

Joe B. Roberts

BOARD OF PHARMACY PUBLIC MEMBER

As a result of changes in the Pharmacy Law, a public member of the North Carolina Board of Pharmacy has been appointed by Governor Hunt. The announcement was made on February 9, 1982 that Joseph B. Roberts, III, Gastonia, was appointed for a three year term expiring April 30, 1984.

Mr. Roberts was born in Gastonia May 24, 1940 and is a graduate of UNC-CH and the UNC Law School. He began practice in Gastonia in 1964 and opened a law office in Mount Holly in 1968. He is presently maintaining a law practice in both offices. Roberts is active in the Democrat Party, having served as Chairman in 1978. He was elected Chairman of the Gaston County Board of Elections in 1977 and recently completed two terms as President of the local county Bar Association.

Roberts is currently a candidate for the North Carolina House of Representatives subject to the June 29 primary and November election. He is a trustee of the Gaston-Lincoln Library Board, a member of the Board of Trustees for the Schiele Museum, and a member of the St. Marks Episcopal Church. He is married to the former Linda McFarland and they have three children; Brad, Scott and Allison.

DILAUDID CRACKDOWN CUTS SUPPLY

By PAUL HASKINS
Sentinel Staff Reporter

A crackdown on Dilaudid has staunched the illegal flow of the drug but has not provided fast relief from the state's No. 1 pharmaceutical narcotic problem.

Drug enforcement agents say black market demand for the potent painkiller remains high, despite an apparent decrease in the street supply, and Dilaudid addicts are willing to pay $50 on the street for a single tablet—25 times the drugstore price.

Keith Bulla, the SBI agent in charge of Dilaudid trafficking, warns that, with street supplies drying up, more addicts may look to unscrupulous or gullible doctors, or forged prescriptions, for their Dilaudid fix.

No. 1 Problem

Some Dilaudid abusers, Bulla said, crisscross the state in search of doctors willing to prescribe the drug. Bulla said Dilaudid ranks at the top of pharmaceutical abuse problems investigated by the multi-agency Diversion Investigative Unit, which he heads.

John Shields, director of the Council on Drug Abuse, the drug counseling and rehabilitation agency here, confirmed that street sales of Dilaudid and addiction to the opiate narcotic are a leading drug abuse problem.

Dilaudid, or hydromorphone, is a painkiller in same opiate class of drugs as heroin and morphine.

25 Addicted

Twenty-five of 61 addicts admitted to CODA's methadone maintenance program for opiate addicts since last July had a Dilaudid habit, Shields said. The rest are addicted to heroin.

Dilaudid has emerged as a sort of cultural drug of choice for white addicts, Shields said. Proportionately more white addicts prefer Dilaudid over heroin, while more black addicts are heroin users, Shields said.

Counselors at CODA say the street price of one four-milligram Dilaudid tablet ranges from $35 to $50. Bulla put the per-tablet price at $50.

By comparison, one local pharmacy reports that a Dilaudid prescription costs $2 per tablet. The wholesale cost to the pharmacy is only 22 cents a tablet, the pharmacy said.

A surprise drug-inventory audit of seven pharmacies in the state by Bulla's drug agency found the pharmacies could not account for more than 30,000 Dilaudid tablets records showed they had ordered. Bulla said the agency plans to continue its crackdown at drugstores. That has resulted in at least two convictions so far.

However, Bulla said that overall black market supplies of Dilaudid have increased at a rate greater than the combined decrease observed in the trafficking of methaqualone and other widely abused pharmaceuticals.

The problem could get worse if, as the agency suspects, more Dilaudid abusers are trying to obtain the drug through legitimate channels. "People are doctor-shopping," Bulla said. "A lot of people are conning physicians into writing prescriptions."

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Pilot Life

DRUGSTORES OFFER GOOD WAY TO SAVE

Sylvia Porter
Universal Press Syndicate

As medical costs soar at a rate far outpacing the inflation rate, more of us are turning to self-medication for minor ailments in an effort to hold down our medical bills. With medical costs up 12.5 percent in 1981, against an inflation rate that abated to the 9 percent range, self-medication appears a good area for economizing.

And with medical expenditures accounting for an astounding 9.4 percent of the nation's output of goods and services (gross national product), it's scarcely surprising that we've decided an estimated 50 percent of all our visits to the doctor may be unnecessary.

The evidence is that the trend to self-medication is growing. For example, the Commerce Department reports that manufacturers' shipments of non-prescription medicines last year were valued at $5.3 billion, up more than 15 percent from $4.6 billion in 1980.

A fascinating sidelight of this trend is our new perception of the ranking of the pharmacist's ethical standards.

The pharmacist now ranks a close second to clergymen in a national sample asked by a recent Gallup Poll to rate the honesty and ethical standards of 24 professional groups. In fact, pharmacists surpassed dentists, doctors, engineers, college professors, police officers, bankers, television commentators and newspaper reports, who in that order rounded out the top 10 professions on the "most trusted" list, according to Drug Topics.

"The constantly improving educational credentials of pharmacists and the wide range of services they perform—from expert filling of prescriptions to phone calls to physicians and patient profiles—plus long hours of work" are among the factors that have put them at the top of the list, said Jack E. Angel, publisher of Drug Topics.

The history of the American pharmacist tracks the medical progress of the nation itself—from primitive medicines to miracle drugs. The corner drugstore was for generations the social center of most communities, and it still is. It was where teenagers met at the soda fountain, and—despite the publicity about teenagers' habits today—it still is where they meet. What difference does it make that the modern super-drugstore offers a variety of goods and services while the drugstore of the early 1900s sold Dr. Campbell's Safe Arsenic Wafers as the "secret to a good complexion?" Some of today's miracle drugs may turn out no safer than those arsenic wafers—despite the pharmacist's educational credentials.

"More and more, people will be turning to their local pharmacist for advice on self-limiting ailments, such as colds, upset stomachs and the like," Angel said. He foresees an increasingly important role for the pharmacist in medicine and a return to the days when he was called "Doc," knew everybody in the neighborhood and always could be counted on for good advice in minor medical emergencies.

If we are to assume a heavier burden of self-medication, we must learn more about our ailments and communicate more clearly with the pharmacist. This is particularly important for the elderly; a patient-pharmacist counseling relationship could be crucial in the elderly's trust and ability to control medical costs.

Equally significant, pharmacists must become more informed about the needs, say, of diabetics. Pharmacists must become more aware of the rising role they can play in hospice care. The closed world of the drugstore is opening wide as a direct result of medical costs. Let it open wider.

MARION LAB PRESENTS NEW RX PROGRAM

Marion Laboratories has announced a new prescription drug program as part of its employees major medical program. The plan was developed after Marion surveyed the various state pharmaceutical associations and individual pharmacists. The plan will be administered by Risk Management Council, Inc., Bentonville, AK, and is based on reimbursement of a pharmacist's usual and customary charges. Each Marion employee, including sales representatives, will be provided a plastic ID card carrying a description of the plan and a toll-free telephone number which the pharmacist can call for more information.

LOCAL NEWS

WAKE COUNTY PHARMACEUTICAL ASSOCIATION

Joni Berry, RPh., M.S. of Wake AHEC, delivered an excellent presentation on "Drug Therapy in the Elderly" for the April meeting. She covered all aspects of possible patient-pharmacist interaction regarding the elderly, from the simple use of compliance aids and drug calenders to the clinical aspects of decreased dosage requirements due to less metabolism/excretion of drug and/or heightened drug action.

WCPhA Officers for 1982-83

President ..... David Devine
President Elect ..... Al Lockamy
Vice President ..... Marshall Hamm
Treasurer ..... John Myhre
Secretary ..... Joni Berry
Executive Committee
Member ..... Buc Murchison

MERONEY APPOINTED TO 2000 COMMITTEE

Carl P. Meroney, Columbus, has been appointed as a co-chairman of the Polk County NC 2000 committee by Governor Jim Hunt. He will assist in putting together a local organization to help make the citizens aware of the future needs and directions for the next two decades. Meroney is a UNC School of Pharmacy graduate and is associated with Columbus Pharmacy.

WHITEHEAD ELECTED TO HOSPITAL BOARD

C. Michael (Micky) Whitehead, Ramseur, has been elected to serve corporate memberships of Randolph Hospital, Inc. He will fill the seat formerly held by his father C. Raymond Whitehead, and will serve a full six year term.

1982-83 Officers of the Wake County Pharmaceutical Association. Left to right: David Devine, Marshall Hamm, Al Lockamy, Buc Murchison, Joni Berry. Staff photo

GUILFORD COUNTY SOCIETY OF PHARMACISTS

The regular monthly meeting of the Guilford County Society of Pharmacists was held on Tuesday evening, April 13, 1982 at Wesley Long Community Hospital, Kiser Building Room 221. Guest speaker for the meeting was Ken Brasfield, Pharm.D., Director of Pharmacy Services, Charter Hills Hospital, Greensboro. His topic for the evening was "Psychiatric Drug Therapy," and the discussion included a review of the use of antipsychotic and antidepressant drugs currently in use.

During the business session following the program, Frank Burton gave a treasurer's report, and reminded those present that many have not yet paid their 1982 dues, urging them to do so as soon as possible. Joe Johnson reported on the "Vial of Life" program being sponsored by the NCPhA Women's Auxiliary, and said he would try to get the slide presentation on this important project to show at the next Society meeting. Several members who had attended the recent NCPhA Convention reported that there was much discussion of the general lack of participation by pharmacists as the major problem the NCPhA has in trying to represent the interests of pharmacists in the state. It was urged that all GCSP members be more active in pharmacy affairs, and get to know their legislators so they can be more effective in "lobbying" for pharmacy.

J. Frank Burton
Secretary-Treasurer

SAVAGE CITED FOR SERVICE TO YOUTH

M. C. Savage, Roanoke Rapids pharmacist, was recently cited for "exerting a positive influence on the community and its youth over the years" by the Community Drug Abuse Committee. Savage was one of two prominent citizens so recognized. He was first licensed in 1940 as a pharmacist, after being licensed in 1927 as an apprentice pharmacist. He served eight years as a city commissioner, has been a director of Rosemary Federal Savings and Loan for 18 years, and is a senior active member of the Rotary club. Savage is married to the former Mackie Price and has one son, Bill, also a pharmacist.

PASSAGE OF "LOOK-ALIKE" LAWS GROWS

Fourteen states have now banned "look-alike" OTC street-drugs according to a recent trade survey. Legislatures in 35 other states are considering a total of 57 separate bills addressing the problem of non-controlled drugs sold in forms resembling controlled substances. One example of such a law comes from Pennsylvania, the site of many street drug look-alike manufacturers, and "prohibits manufacture, processing, packaging, distribution or selling of a non-controlled substance that has a stimulant or depressant effect on humans, other than a prescription drug, which, or the label or container of which, substantially resembles a specific controlled substance."

RITE AID PURCHASES MANN DRUG

Rite Aid has purchased the 27-store Mann Drug chain, headquartered in High Point for an undisclosed amount of cash. Eight of the Mann stores are located in High Point, as is the Mann Drug distribution center.

The acquisition gives Rite Aid 993 drug stores and the 1000th store will be opened in Durham in May.

EDUCATION CENTER NAMED FOR DECEASED PHARMACIST

Members of the Transylvania County Board of Education have unanimously voted to name the Education Center in honor of the late Eugene M. Morris.

Morris, former owner of Morris Pharmacy in Brevard, was shot and killed April 11, 1981, in Asheville. He was appointed to the County Board of Education in 1961 and served until April 1976. He was board chairman from 1974-76.

The committee recommended the Education Center be named for Morris rather than one of the school, because his interest was in the county-wide system rather than a particular school or facility, according to a spokesman for the county.

A PREVIEW OF 1981 HOSPITAL PHARMACY OPERATIONS

This report includes selected operating data tabulated to reflect a composite profile of the "average" hospital pharmacy in the United States for 1981. Because this hypothetical pharmacy is derived mathematically from a broad range of information, the figures may be too general to use for direct comparison. However, trends can be determined by comparing the data with similar figures from the 1980 survey of operations.

The data show that the average hospital had a bed capacity of 259 in 1981—a 4.4 percent increase from the previous year and the same bed capacity as that reported in 1979. Census declined from 74 to 73 percent during 1981. Admissions increased from 8573 to 9212 (an increase of 7.5 percent), which resulted in a shorter period of patient stay—7.5 days. The largest segment of reporting hospitals continues to be private (nonprofit) general institutions.

The number of hours worked by pharmacists and technicians as well as the hours the central pharmacy was open rose during the 1981 reporting period. Overall, 2.8 hours of pharmacist time and 2.6 hours of technician time were required for each hour the central pharmacy was open during 1981. A comparison of total hours worked per week by the pharmacy staff in 1981 with similar data for 1980 reveals that total pharmacy staff requirements increased somewhat.

The dollar values reported for inventory and purchases were higher during 1981 (up 1.2 and 12.3 percent respectively). The estimated inventory turnover rate showed significant growth from 5.3 to 6.1 times. It is interesting to notewthat, if the inventory turnover rate had remained at 5.3 during 1981, inventory costs at $104,416 would have been over $16,000 higher and shown an increase of 16.8 percent. That hospital pharmacy managers exercised control over inventory, as demonstrated by the improved turnover rate during 1981, is particularly revealing, since last year was one of continued price increases.

Inventory and purchases on a per-bed basis were also higher than those reported in last year's *Survey*. However, because the data do not take inflation into account, it is impossible to determine the extent of its impact on inventory and purchases figures. Therefore, the amounts shown do not necessarily reflect expanded usage of drugs and related items by hospital patients.

Services offered by over 50 percent of hospital pharmacies responding to the *Survey* remained unchanged from the previous year. Monitoring of drug interactions showed the largest growth rate during the two-year period 1980-1981, with 87 percent reporting this service in 1981 as compared with just under 83 percent for 1980, which suggests that hospital pharmacists are continuing to expand clinical services.

A comparison of selected operating statistics over the six-year period for which the *Lilly Hospital Pharmacy Survey* has been in existence demonstrates the following trends:

—Pharmacy hours open have risen from 74 to 91 (an increase of 23 percent).
—Pharmacist hours worked per week have increased 71.1 percent (from 152 to 260 hours).
—Technician hours worked per week have varied but have increased overall from 129 to 240 (an 86 percent rise).
—Inventory investment has increased 52.1 percent, and the annual six-year growth rate is 8.7 percent.
—Monies spent on purchases have increased 96.3 percent over the six-year period, with an annual growth rate of 16.1 percent.

The 1982 edition of the *Lilly Hospital Pharmacy Survey* will be distributed in September of this year.

AVERAGE HOSPITAL PHARMACY
Preliminary Report

	1981 (1694 hospitals)	1980 (2152 hospitals)	Percent of Change
Bed capacity	259	248	+4.4%
Class	Private (nonprofit)	Private (nonprofit)	
Profile	General	General	
Census (beds occupied)	73%	74%	
Admissions	9212	8573	+7.5%
Length of patient stay	7.5 days	7.8 days	
Hours central pharmacy open/week	91	90	+1.1%
Pharmacist hours/week	260 (6.5 F.T.E.)	243 (6.1 F.T.E.)	+7%
Technician hours/week	240 (6.0 F.T.E.)	231 (5.8 F.T.E.)	+3.9%
Inventory	$104,416	$103,211	+1.2%
	$ 1.51/Patient day	$ 1.54/Patient day	
	$ 403/Bed	$ 416/Bed	
	$ 552/Occupied bed	$ 562/Occupied bed	
	$11.33/Admission	$12.04/Admission	
Purchases	$638,903	$569,045	+12.3%
	$ 9.26/Patient day	$ 8.49/Patient day	
	$ 2467/Bed	$ 2294/Bed	
	$ 3379/Occupied bed	$ 3101/Occupied bed	
	$69.35/Admission	$66.38/Admission	
Inventory turnover rate	6.1 times	5.3 times	
Floor area (central pharmacy)	1623 sq. ft.	1524 sq ft	
Services offered by over 50% of pharmacies			
	Monitoring patient profiles	Monitoring patient profiles	
	Monitoring drug interactions	Monitoring drug interactions	
	Providing drug information services	Providing drug information services	
	Drug therapy consultation	Drug therapy consultation	

ACA HEALTH STYLE STUDY

A community pharmacist can be an effective health educator and modifier of health style and attitude toward health. This represents the major finding of an American College of Apothecaries, Research and Education Foundation sponsored project entitled "Effectiveness of Education Provided By the Community Pharmacist in Modifying Patron Attitudes and Behavior Toward Health."

In the study, a community pharmacist/researcher provided health style education and recommendations to improve health style to randomly selected community pharmacy patrons. The six areas of health included tobacco/smoking, alcohol and drugs, exercise/fitness, stress, eating habits and safety.

The results of the study demonstrated that pharmacist intervention significantly modified consumer behavior with respect to tobacco/smoking, exercise/fitness and safety. The modification resulted in the adoption of positive health behavior. Results also indicated that pharmacist intervention significantly modified consumer attitudes with respect to alcohol and drugs, eating habits and exercise/fitness. The modification resulted in an increased awareness of the benefits of health behavior and the adoption of a more positive attitude with respect to such behavior.

In conclusion, the study reports that health education provided by a community pharmacist can modify consumer behavior and attitudes. Improvements in health behavior and consumer attitudes were observed following pharmacist consultation.

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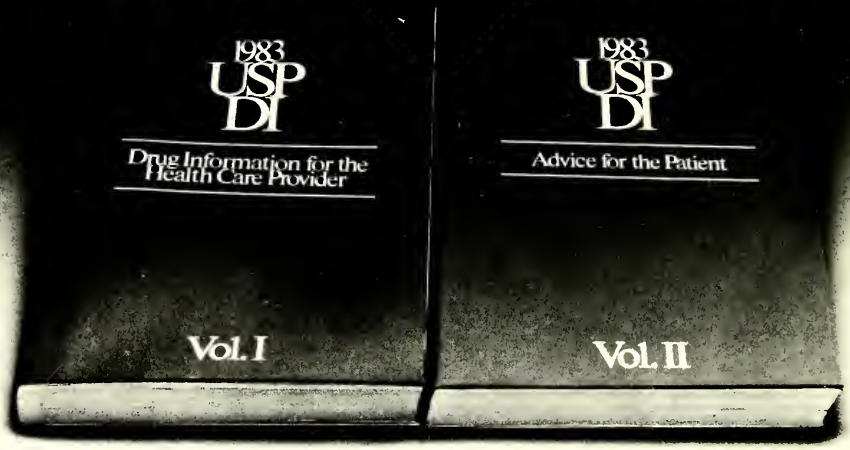

THE 1983 USP DI, NOW IN TWO VOLUMES.

Now more than ever, patients are turning to their pharmacists for advice about drug products. That's why more pharmacists around the country turn to *USP Dispensing Information (USP DI)* as the definitive reference for drug use information. Now the United States Pharmacopeia is offering a newly expanded and updated edition, available for the first time as a two-volume set.

Volume I, designed for use by the pharmacist, contains detailed dispensing information on over 4,500 drug dosage forms and brands. Volume II is a corresponding lay language guide for patients with instructions on the proper use, precautions and side effects of their medicines.

In addition to the new two-volume *DI,* USP is offering the consumer paperback *About Your Medicines* and a free kit of advertising and publicity tools to help you promote your patient education program. To order your copies, just mail in the coupon below.

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TO ALL PILOT LIFE GROUP HEALTH INSURANCE POLICYHOLDERS

We at Pilot share your concern about the rising costs of your group health insurance benefits. In spite of the sluggish economy over the last year or so, medical care cost inflation has continued to rise steadily, and use of medical services has remained exceptionally high. As your group insurance underwriter, we think you should know how we feel about the situation—the prospects for the future, what we recommend, and what Pilot Life is doing about the problem.

Among the current problems we all face are:

- Most providers of medical care have no financial incentive to contain or reduce costs. The more services they provide, the more money they receive.
- Consumers (employees) have insufficient incentive to be concerned about costs since insurance with few or no co-payment features like deductibles and co-insurance enables them to receive services with little direct cost.
- The federal government is reducing its share of expenses for Medicare/Medicaid patients, with the result that the unpaid balance is shifted to privately-insured or cash-paying patients. This "cost-shifting" means that private sector patients are subsidizing public sector patients' health care costs because of inadequate government reimbursement under the Medicare and Medicaid programs. Cost shifting is a hidden factor in escalating health care costs. It is equivalent to an additional tax.
- Providers and employees have not been encouraged properly to use less expensive forms of care. Treatment patterns established when many insurance plans encouraged expensive hospitalization have not changed. Most plans now provide coverage for alternative and less-expensive methods of treatment (e.g. out-patient surgery, second opinions, pre-admission testing, etc.).
- Hospitals compete for patients and frequently construct facilities not actually needed and duplicate equipment already available at other area hospitals (e.g. CAT Scanners). This contributes to insufficient utilization and increased cost per unit.
- There is little or no cost competition among doctors and hospitals to encourage efficiency of operation and lower costs.
- Employers, who pay the bulk of cost through group plans, cannot individually exert needed pressure on providers to contain costs through greater efficiency and economies of operation.

Since there is no single cause of medical care cost inflation, there is no single cure to prescribe. Some recommendations which we feel will help in attacking and overcoming these problems are:

- Thoughtful design of benefit schedules should increase employee cost-sharing through higher deductibles and coinsurance. As employees have more stake in costs, they as consumers are likely to demand and ultimately get more for their money.
- Encourage employees to voice concerns about costs when discussing treatment patterns with their doctor. Direct discussion with the provider of care is perhaps the most effective cost control technique available.
- Plans should also be designed to encourage use of less expensive forms of service by paying a higher portion of covered expenses when the patient is not hospital confined. Pilot Life pioneered this concept with its Control-Med plans and will announce soon still another step with a series of "basic" or "no-frills" plans.
- Pilot Life's new Claims Control Unit will also help by reviewing claims more closely for conformance with reasonable and customary standards.
- Employers should join together, whenever possible, to have a greater voice with providers and also to seek enabling legislation for Medicare/Medicaid waivers which would stop the federal government's shifting of costs of Medicare/Medicaid patients to the private sector. Serving on Cost Containment Coalitions, hospital boards, regional health planning agencies, and similar groups would help encourage provider efficiency and lower costs.

(continued next page)

Pilot Life

- Pilot Life is prepared to furnish policyholders reports from its PACE claims system, detailing how, where, and to whom your benefits dollars are being paid. This is a necessary first step to the consideration of other cost containment measures.
- Another effective means of containing medical care costs is to attack the root cause—by keeping employees healthier. Wellness programs are being adopted by many employers across the country. These programs encourage employees to take better care of themselves through exercise, proper diet, weight control, and reduction of smoking and alcohol consumption. Pilot Life has specific recommendations for your consideration in our Health Education and Lifestyle Planning program. We will be pleased to send you more details upon request.

Thank you for your concern over these problems. We appreciate your business and share your concerns. We urge you to participate in as many of the recommended actions as possible. We think that collectively they offer the best hope for regaining control over today's rapidly rising costs of medical care and treatment.

Sincerely,

G. B. Blanton, CLU

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ADVISORY-GENERIC DRUGS

Ross S. Laderman
Director, Consumer and Professional Relations Staff, Bureau of Drugs

Recently there has been an increase in media attention to issues surrounding the safety and effectiveness of generic drugs marketed in the United States. A segment aired last month on a national news television program reported on the death of an Ohio woman which was attributed to the ingestion of unapproved generic furosemide tablets obtained in the marketplace and subsequently dispensed on prescription.

The large increase in the number of generic drugs on the market is the result of several factors. Among these are: 1) expiration of patents on a number of drugs with large market potential, 2) passage of drug substitution laws by State legislatures, and 3) challenges to federal drug laws in a number of legal actions. These and other factors have encouraged firms to enter the market with generic counterparts in a rapid manner, in some instances without the approval of the Food and Drug Administration even though such approval may have been required. We have proceeded with a number of regulatory actions which have resulted in removal of many unapproved drugs from the market. In fact, we believe that no new unapproved generics have entered the marketplace during the past year.

However, we caution pharmacists that there may still be unapproved drugs which entered the market previously that still remain on wholesale and retail shelves. Such products may possess safety and/or effectiveness problems and we encourage pharmacists to examine their stocks. The approval status of marketed drugs as well as their therapeutic equivalence is detailed in *Approved Prescription Drug Products With Therapeutic Equivalence Evaluations* distributed on subscription by the U. S. Government Printing Office. Interested persons may subscribe (at a fee) or call FDA's Bureau of Drugs at (301) 443-1016 to obtain the status of any drug in question.

Should we become aware that unapproved drugs with significant medical implications are again entering the market, we will alert you by one of these advisories.

We would appreciate it if you would give this information the greatest possible circulation among your memberships and patrons. We believe it will answer some questions in the professional community.

Should any questions arise, we will be pleased to provide whatever information is needed. We can be contacted at (301) 443-1016.

Ross S. Laderman
Director
Consumer and Professional
Relations Staff
Bureau of Drugs (HFD-5)

CEKADA HONORED IN ALASKA

Emil L. Cekada was honored as February Man of the Month for the Alaska Area Native Health Service. Cekada is Chief of the Pharmacy Section, Area Patient Care Services Branch and was selected for his outstanding willingness to be of help whenever called upon.

Cekada was born in Durham, North Carolina. Cekada's academic credits include a BS in Chemistry from the College of William and Mary; a BS in Pharmacy from the University of North Carolina, and a Masters in Public Health Degree in Public Health Administration from the University of Minnesota. He is a member of the RHO CHI Pharmacy Honor Society and received the Lehn and Fink Gold Medal Award for Noteworthy Achievement in Pharmacy. He is also a member of the Phi Delta Chi Professional Pharmaceutical Fraternity and was recognized in 1978 for his outstanding achievement when awarded a painting created by the noted artist Robert Thom by Parke Davis Pharmaceutical Company.

Recently, he was presented with the "Bowl of Hygeia" Award for Outstanding Community Service in Pharmacy at the Annual Meeting of the Alaska Pharmaceutical Association. The "Bowl of Hygeia," most widely recognized International symbol of pharmacy, had its origin in Greek mythology. The Bowl, containing a healing potion and the serpent, meaning wisdom or guardianship, were associated with the Goddess of Health, Hygeia and her father the God of Medicine and Healing, Aesculapius. When A. H. Robins established in 1958 an award honoring community service by pharmacists, the "Bowl of Hygeia" design was a natural choice to symbolize such an award, which is presented annually.

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PHARMACY & POPULATION STATISTICS
Published by: N. C. Board of Pharmacy
P. O. Box H, Carrboro, NC 27510

COUNTY	R/Ph 1/82 (Res)	1980 Census	Pop/R. Ph.	Phar 1/82	m. Pop/Phcy
ALAMANCE	54	99,319	1,839	29	3,425
ALEXANDER	13	24,999	1,923	6	4,166
ALLEGHANY	6	9,587	1,598	3	3,196
ANSON	7	25,649	3,664	5	5,130
ASHE	8	22,325	2,791	6	3,721
AVERY	9	14,409	1,601	5	2,882
BEAUFORT	26	40,355	1,552	11	3,669
BERTIE	7	21,024	3,003	5	4,205
BLADEN	12	30,491	2,541	9	3,388
BRUNSWICK	15	35,777	2,385	12	2,981
BUNCOMBE	140	160,934	1,149	51	3,156
BURKE	47	72,504	1,543	25	2,900
CABARRUS	55	85,895	1,561	22	3,904
CALDWELL	29	67,746	2,336	17	3,985
CAMDEN	1	5,829	5,829	1	5,829
CARTERET	24	41,092	1,712	13	3,161
CASWELL	4	20,705	5,176	3	6,902
CATAWBA	83	105,208	1,286	41	2,566
CHATHAM	29	33,415	1,152	7	4,774
CHEROKEE	11	18,933	1,721	8	2,367
CHOWAN	5	12,558	2,512	4	3,139
CLAY	4	6,619	1,654	2	3,309
CLEVELAND	45	83,435	1,854	28	2,980
COLUMBUS	32	51,037	1,595	16	3,190
CRAVEN	31	71,043	2,292	16	4,440
CUMBERLAND	82	247,160	3,014	32	7,724
CURRITUCK	1	11,089	11,089	1	11,089
DARE	8	13,377	1,672	5	2,675
DAVIDSON	48	113,162	2,358	29	3,902
DAVIE	20	24,599	1,229	5	4,920
DUPLIN	18	40,952	2,275	15	2,730
DURHAM	139	152,785	1,099	44	3,472
EDGECOMBE	19	55,988	2,947	19	2,947
FORSYTH	202	243,683	1,206	63	3,868

(continued next page)

PHARMACY & POPULATION STATISTICS

FRANKLIN	16	30,055	1,878	9	3,339
GASTON	91	162,568	1,786	39	4,168
GATES	0	8,875	0	2	4,437
GRAHAM	3	7,217	2,405	2	3,608
GRANVILLE	25	34,043	1,361	13	2,619
GREENE	3	16,117	5,335	1	16,117
GUILFORD	237	317,154	1,338	104	3,049
HALIFAX	28	55,286	1,974	19	2,910
HARNETT	28	59,570	2,127	18	3,309
HAYWOOD	35	46,495	1,328	15	3,100
HENDERSON	41	58,580	1,429	20	2,929
HERTFORD	17	23,368	1,375	8	2,921
HOKE	9	20,383	2,265	5	4,077
HYDE	0	5,873	0	2	2,936
IREDELL	55	82,538	1,501	27	3,057
JACKSON	13	25,811	1,985	7	3,687
JOHNSTON	35	70,599	2,017	21	3,362
JONES	2	9,705	4,852	2	4,852
LEE	24	36,718	1,530	12	3,060
LENOIR	38	59,819	1,574	22	2,719
LINCOLN	27	42,372	1,569	12	3,531
McDOWELL	17	35,135	2,067	9	3,904
MACON	13	20,178	1,552	9	2,242
MADISON	7	16,827	2,403	8	2,103
MARTIN	12	25,948	2,162	9	2,883
MECKLENBURG	251	404,270	1,611	104	3,887
MITCHELL	9	14,428	1,603	7	2,061
MONTGOMERY	12	22,469	1,872	7	3,210
MOORE	34	50,505	1,485	14	3,607
NASH	46	67,153	1,460	14	4,797
NEW HANOVER	84	103,471	1,232	33	3,135
NORTHAMPTON	7	22,584	3,226	5	4,517
ONSLOW	28	112,784	4,028	14	8,056
ORANGE	158	77,055	488	16	4,816
PAMLICO	3	10,398	3,466	1	10,398
PASQUOTANK	15	28,462	1,897	10	2,846
PENDER	5	22,215	4,443	6	3,702
PERQUIMANS	5	9,486	1,897	1	9,486
PERSON	15	29,164	1,944	9	3,240
PITT	91	90,146	991	26	3,467
POLK	8	12,984	1,623	6	2,164
RANDOLPH	50	91,728	1,835	19	4,828
RICHMOND	21	45,481	2,166	12	3,790
ROBESON	43	101,610	2,363	25	4,064

(continued on next page)

PHARMACY & POPULATION STATISTICS

ROCKINGHAM	47	83,426	1,775	27	3,090
ROWAN	57	99,186	1,740	25	3,967
RUTHERFORD	28	53,787	1,920	18	2,988
SAMPSON	30	49,687	1,656	15	3,312
SCOTLAND	17	32,273	1,898	12	2,689
STANLY	24	48,517	2,022	11	4,411
STOKES	12	33,086	2,757	7	4,727
SURRY	37	59,449	1,607	23	2,585
SWAIN	3	10,283	3,428	5	2,057
TRANSYLVANIA	13	23,417	1,801	6	3,903
TYRRELL	1	3,975	3,975	1	3,975
UNION	30	70,380	2,346	14	5,027
VANCE	8	36,748	4,593	9	4,083
WAKE	267	301,327	1,129	86	3,504
WARREN	4	16,232	4,058	6	2,705
WASHINGTON	4	14,801	3,700	3	4,934
WATAUGA	22	31,666	1,439	10	3,167
WAYNE	43	97,054	2,257	24	4,044
WILKES	25	58,657	2,346	12	4,888
WILSON	46	63,132	1,372	17	3,714
YADKIN	13	28,439	2,188	9	3,160
YANCEY	4	14,934	3,733	3	4,978
TOTAL	**3,630**	**5,881,736**	**1,620 (Average)**	**1,625**	**3,620 (Average)**

Avoid delay in receiving your NCPhA mail.
Please print your NEW ADDRESS below:

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Effective Date

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BODY FAT DISTRIBUTION

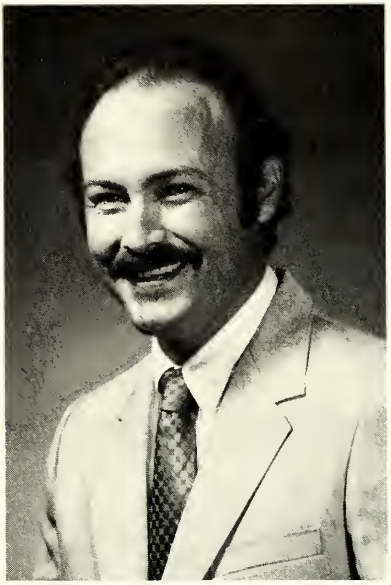
The distribution of body fat above and below the waist may indicate the likelihood of diabetes mellitus development in women. Women who have more fat above the waist are more likely to have problems with carbohydrate intolerance than those whose fat deposits are primarily in the hips, thighs, and buttocks. The fat cells in the lower part of the body have normal characteristics while those obtained from above the waist are generally enlarged, engorged with fat, and have a lower insulin receptor density. *J Am Med Assoc,* Vol. 247, #6, p. 731, 1982.

WEIGHT LOSS

Balloons were placed into the stomach of five obese women and then were inflated with a catheter and left to float about freely in the organ. While inflated, the balloon produced a feeling of satiety and the patient lost weight because of reduced food intake. When the balloon became deflated, it passed out uneventually with the stool. Before this method can be more universally used, a balloon resistant to acid needs to be perfected. *Lancet,* Vol. I, #8265, p. 198, 1982.

FISH FAT

Studies conducted in people living in areas where fish is the major source of food have shown that there is a lower incidence of atherosclerosis, thrombus formation and myocardial infarction than is found in other areas of the world. It has been postulated that an analog of arachidonic acid, eicosapentaenoic acid (EPA), found in high concentrations in fish, may be responsible for producing the beneficial effects. EPA is incorporated into human platelet lipid membranes in the place of arachidonic acid thus decreasing the amount of thromboxane A-2 which can be formed by the platelet. Since thromboxane A-2 is associated with platelet aggregation and thrombus formation, reducing its activity in these areas may help explain the lower incidence of these cardiovascular complications in patients with high fish intake. *J Am Med Assoc,* Vol. 247, #6, p. 729, 1982.



Jerry Cole
Burroughs Wellcome Co.

Research Triangle Park, NC—Gerald R. Cole has recently graduated from an intensive sales training course as the final phase of a 30-week program for the position of Sales Representative for Burroughs Wellcome Co.

Cole, a native of Lenoir, North Carolina, graduated with B.A. and M.A. degrees from Appalachian State University. He will be working out of Hickory, North Carolina.

PROPRANOLOL DOSING

Propranolol (Inderal) has been said to produce sustained beta-adrenergic blockade but only if given in four daily doses. In order to test this observation, the drug was used in doses of 80 mg twice daily or 40 mg four times daily. The plasma levels of 19 volunteers were monitored and after seven days of therapy it was concluded that the relative rate and extent of propranolol absorption was greatest after the twice-daily dosing schedule. In addition, the use of the drug in two daily doses also produced smaller variations in "area under the curve" calculations. Clinical studies will now follow to determine if patients requiring sustained beta adrenergic blockade can use propranolol in this manner. *J Clin Pharmacol,* Vol. 21, #11, p. 472, 1981.

PHARMACY CRIMES

LEXINGTON

An undisclosed amount of money was taken from Eckerd Drug—Talbert Street by a black male armed with a pistol, Tuesday night, May 18. The man entered the store about 9:00 p.m. browsed for a few minutes before approaching an employee, pulling out a long pistol and demanding money.

FRANKLIN

Revco Drug Store was broken into early Friday morning, May 14, and one bottle of Dilaudid and two bottles of Quaalude were taken. Entry was gained by knocking a hole in a rear wall with a sledgehammer. The alarm proved to be faulty and only sounded in the store and not in the sheriff's office.

LUMBERTON

An armed white male robbed Revco Drug Store Monday night, February 8, of an estimated $300 in cash and a quality of controlled drugs, including Valium, Quaalude, Dilaudid and Preludin.

CHAPEL HILL

Vandals struck Rite Aid Pharmacy Monday night, May 24, breaking out glass in the front door. Damage was estimated at $200, although the store was not entered.

REIDSVILLE

A Durham man was arrested and charged with attempting to pass a forged prescription at Link Brothers Pharmacy, Thursday, May 6.

NEWTON

Newton police have arrested a Lincolnton man and charged him with forging 42 prescriptions between July 1981 and February, 1982. The prescriptions were allegedly forged on three physicians and two dentists and were all for Oxycodone.

DANBURY

Two men robbed the Stokes-Reynolds Hospital pharmacy of about $1,000 in cash and a quantity of drugs, Monday night January 25. According to reports, the men entered the pharmacy about 5:45 and tied up pharmacist Tom Zok and a customer, took the drugs and cash, and escaped in a waiting van.

WARSAW

Vandals broke out the rear door window of Warsaw Drug Company, Wednesday, March 25. Two other businesses in the area were similarly vandalized, and no entry was reported.

FORGERIES

Pharmacies have reported receiving forged prescriptions on pre-printed Rx blanks from Dr. Clinton B. Davis, II, Duke University Medical Center. The name most often used as the patient is Bernice Chavis.

ROXBORO

Roxboro police are looking for a black male who passed two forged prescriptions at the Medicine Shoppe, Monday, May 10. The blanks were apparently stolen from the Medical Arts Building in Durham, with Dr. E. S. Williams named forged.

You are Cordially Invited

to the

Mortar-and-Pestle Award Dinner

honoring

W. Thomas Boone

1982 Pharmacist-of-the Year

Friday evening
July 23, 1982
7:30 p.m.
The Ahoskie Methodist Church

Reception
502 N. Curtis Street
6:00p.m.

Mr. Boone has been chosen for this high honor by the North Carolina Pharmaceutical Association, and the announcement was made at the opening session of the 102nd Annual Convention in Winston-Salem, N.C., April 6, 1982.

Mr. Boone's contributions in pharmacy and his community which led to this award will be recognized by friends and professional associates during the program following the dinner.

The Mortar-and-Pestle Award which he will receive, is the most coveted award granted by the North Carolina Pharmaceutical Association and will be presented by Marshall Sasser, immediate past president of the Association. Current NCPhA President Ernest J. Rabil will preside at the meeting.

You may make your reservation for the dinner honoring Mr. Boone by returning the reservation form below not later than July 9, 1982. You may also request overnight housing at the Tomahawk Motel, Ahoskie, by checking the appropriate space below.

= =

MAIL TO: A. H. Mebane, III, NCPhA, P.O. Box 151, Chapel Hill, NC 27514

Please reserve ____places for the Pharmacist-of-the-Year Dinner at $9.00 each (wives/husbands of members are most cordially invited). My check, made payable to NCPhA is enclosed.

Name _____

MAILING ADDRESS _____

_____ZIP_____ TELEPHONE ( ) _____

[ ] Please make a reservation for the evening of July 23 at the Tomahawk Motel, Ahoskie. I will pay for this overnight lodging when checking out of the motel on July 24th.

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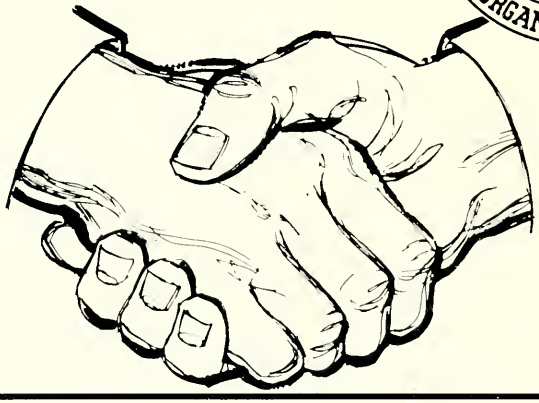

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CONVENTION FINANCIAL CONTRIBUTORS

Continuing education programs are the backbone of any successful convention and special thanks go to those companies which support these programs through contributions. Since several checks are received after the official convention program is printed, we are pleased to list the contributors in this issue of the Carolina Journal of Pharmacy.

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84th Annual NARD Convention and Pharmacy Trade Exposition. Boston, October 10-14, 1982. Fall Foliage Bus Trip, NCPhA Sponsored, October 14-17.

CONVENTION GOLF TOURNAMENT

Winners in the NC. Pharmaceutical Association Convention Golf Tournament, sponsored by Owens-Illinois, were:

1. *TMA*
   Low Net—1st—David Kennedy
   2nd—Steve Munshower
2. *NCPHA*
   Low Net—1st—Reagan Harper
   2nd—Bill Wilson

Low Gross:

1. *TMA*
   Rusty Hamrick
2. *NCPHA*
   Gene Butler

Closest To The Pin—Jimmy Creech
Longest Drive—Jack Friday

RABIL FEATURED IN NARD JOURNAL

Ernest J. Rabil, President-elect of the North Carolina Pharmaceutical Association is featured in the March 1982 NARD Journal, in the article "It Keeps Me On My Toes," beginning on page 11. The article chronicles Rabil's entry into the nursing home provider/consultant field and the challenges he encountered.

RAYNAUDS PHENOMENON

A vasospasm of digital vessels may result in sensations of coldness in the hands known as Raynauds phenomenon. Captopril (Capoten) is a converting enzyme inhibitor used primarily to treat high renin hypertension, but recently it was found to also be effective in relieving the discomfort of Raynauds phenomenon. Since this alteration in temperature perception is not thought to be associated with excessive angiotensin II activity, it has been suggested that captopril exerts its beneficial effect by allowing for the accumulation of circulating kinins. The kinins produce vasodilation and increase perfusion through the extremity. *Br Med J,* Vol. 284, #6312, p. 312, 1982.

RITE OF ROSES IN MEMORIAM

Presented by Mr. & Mrs. W. A. West at the 102nd Annual Convention of the North Carolina Pharmaceutical Association on Monday, April 5, 1982, Winston-Salem, NC.

We pause at this time to pay tribute to our members, who since we last met, have been called to a greater service beyond Earths existence.

It is certainly well that we honor those who are no longer with us but who live in our thoughts and memories. Each of these members will be remembered for their own contribution to the profession of Pharmacy, for their friendship, loyalty, and dedication to the service of mankind through their work here on earth.

The Rite of the Roses Ceremony is a beautiful symbol of the lives that are represented by the roses we place in the vases here to be seen throughout our convention days together.

Death seems to be such a final thing, but really we know that it is a deceiver. At this time of the year new life is springing forth in all of nature and certainly it would not be so had not the seed fallen in the ground and died only to germinate to new life. So it is with our friends who have joined that innumerable band who now serve in a different environment.

Whittier said it well.

God calls our loved ones, but we lose not wholly what he has given,

They live on earth in thought and deed, as truly as in Heaven.

RITE OF THE ROSES

Thomas Roy Burgiss, Sparta—March 3, 1982
Joseph Arnold Creech, Selma—April 27, 1981
David Ramsey Davis, Williamston—July 14, 1982
Reid Bridges Grantham, Red Springs—May 9, 1981
George William Honeycutt, Rockingham—March 2, 1982
Donald J. Miller, Morganton—November 10, 1981
Walter Lee Moose, Mt. Pleasant—November 11, 1981
Stephen Carroll Morris, Bayboro—May 31, 1982
Marshall Louis Newbern, Wilson—February 5, 1982
Richard Buxton Overton, Jr., Raleigh—December 8, 1981
Thurman Quinton Owens, Whiteville—June 6, 1981
William Jay Swan, Bryson City—September 21, 1981

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MARRIAGES, BIRTHS & DEATHS

MARRIAGES

JUNE CELESTE HALL and William Michael McDermott exchanged marriage vows on Saturday, December 19. The double ring ceremony was performed by the Rev. Daniel J. Riggall at the Chapel of the Cross, Chapel Hill.

The bride received a BS in pharmacy from the UNC School of Pharmacy at Chapel Hill and did a residency in hospital pharmacy at Duke University Medical Center. Currently she is a clinical instructor at the UNC School of Pharmacy. The bridegroom, who has a BS in Biology from UNC-CH, is presently a dental student at UNC-CH. The couple resides in Chapel Hill.

THERESA ANN MICHAUD and FRED WILSON LOWRY, JR., were united in marriage March 19 in Statesville at Westerna Avenue Baptist Church. The Rev. Ralph Carter and the Rev. Edward J. Beatty officiated.

The bride is a graduate of the UNC School of Pharmacy and is employed at Davis Hospital in Statesville. The groom graduated from Pharmacy School at the University of South Carolina in Columbia, S. C. and is employed at Lowry Drug Store in Statesville. The couple will live in Statesville.

JAN GRAY LASSITER and David Ray Humphrey, both of Wilmington, were married Saturday May 29, in First Presbyterian Church, Rocky Mount.

The bride is a graduate of the University of North Carolina School of Pharmacy and is a pharmacist at Eckerd Drugs. The groom is an agent for Western-Southern Life.

DEATHS

David Edgar Sutliff

Word has been received that David Edgar Sutliff, Eustis, Florida, died this year. Mr. Sutliff graduated from the University of Michigan College of Pharmacy in 1949 and worked at Lane Rexall Drugs, Greensboro before moving out of the state. He had been a member of the NCPhA since 1964.

BIRTHS

Benjamin and Laveita Brinson, Washington announce the birth of their second son, Adam Thomas Brinson. Benjamin (UNC 1972) is employed by Taylore Drug Company, Washington, NC.

JOHN OLAN and Susan Williamson Brown are happy to announce the birth of their daughter Amanda Anne on March 30, 1982. John is a 1971 graduate of UNC School of Pharmacy and is Manager of Pharmaceutical Services for the North Carolina Department of Correction.

BLUE CROSS/SHIELD NOTICE

Blue Cross and Blue Shield of North Carolina has made some program changes affecting reimbursement for drugs. It is now necessary for the drug name and strength to appear on the claim form and the receipt provided the patient. This information is needed to determine whether or not the drug is covered and to make benefit allowance determinations. The cooperation of the pharmacist in providing this information will speed up claims processing and reduce needless correspondence and duplication of claims.

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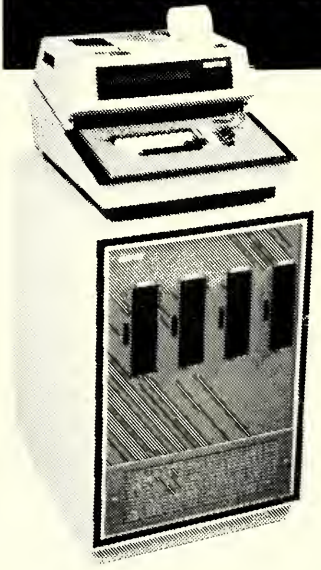

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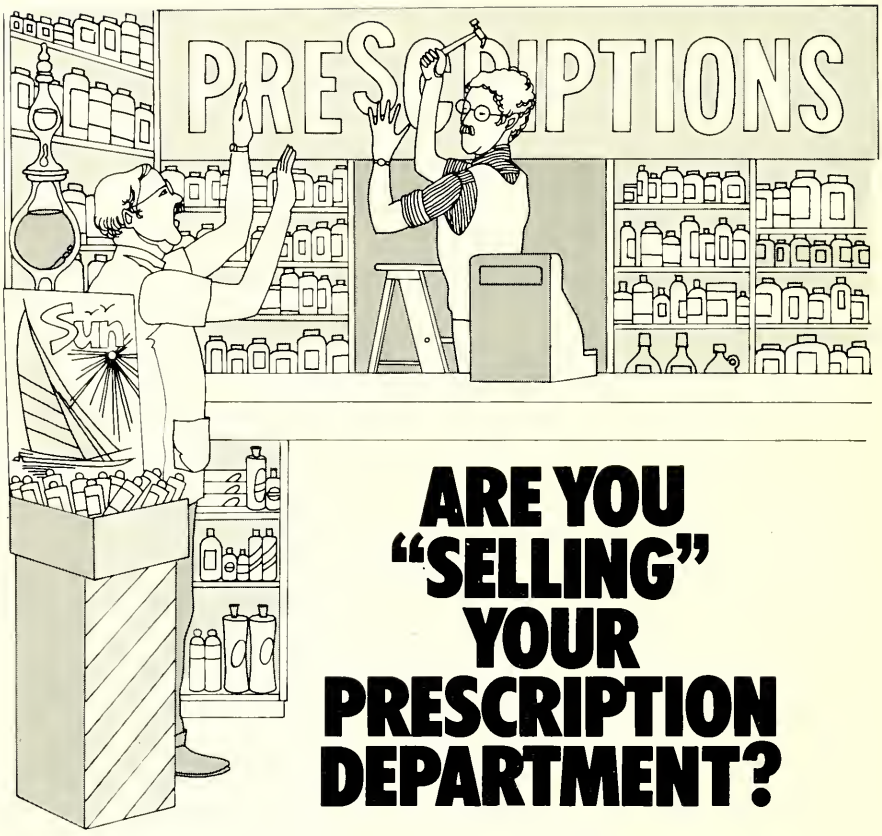

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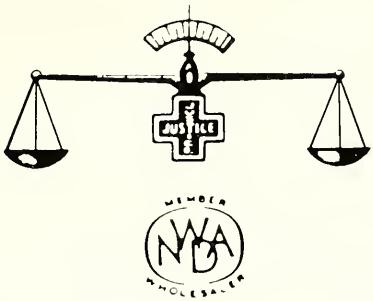

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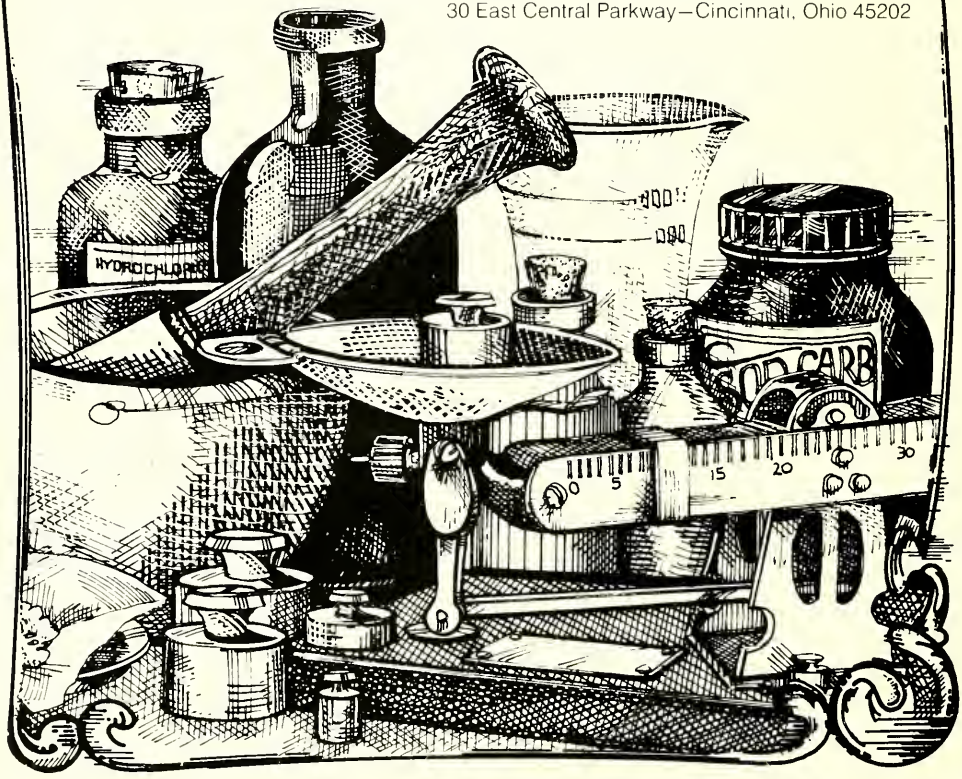

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JUNE 1982 VOLUME 62 NUMBER 6

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Thanks, Northeastern University

College of Pharmacy
Boston, Massachusetts

These young people recently spent a very full day at Abbott, touching bases in research, development and production.

Many of them were impressed—and said so—with the hundreds of steps and precautions taken to assure a top-quality product.

We were impressed, too—with them.

They were bright, curious, professional and very excited about their careers.

It was a good day. And one way we know of starting—and keeping—a dialogue.

ABBOTT

1083417

THE REVISED PHARMACY PRACTICE ACT

effective July 1, 1982
(New Sections in Bold Face)

The General Assembly of North Carolina enacts:
Section 1. Part 1 of Article 4 of Chapter 90 of the General Statutes is rewritten to read:

"ARTICLE 4.
"North Carolina Pharmacy Practice Act.

"§ 90-53. Legislative findings—The General Assembly of North Carolina finds that mandatory licensure of all who engage in the practice of pharmacy is necessary to insure minimum standards of competency and to protect the public from those who might otherwise present a danger to the public health, safety and welfare.

"§ 90-54. Definitions—(1) 'Administer' means the direct application of a drug to the body of a patient by injection, inhalation, ingestion or other means.

(2) 'Board' means the North Carolina Board of Pharmacy.

(3) 'Compounding' means taking two or more ingredients and combining them into a dosage form of a drug, exclusive of compounding by a drug manufacturer, distributor, or packer.

(4) 'Deliver' means the actual, constructive or attempted transfer of a drug or device from one person to another.

(5) 'Device' means an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent or other similar or related article including any component part or accessory, that is required by law to be dispensed only pursuant to a prescription order.

(6) 'Dispense' means preparing and packaging a prescription drug or device in a container and labeling the container with information required by State and federal law. Filling or refilling drug containers with prescription drugs for subsequent use by a patient is 'dispensing.' Providing quantities of unit dose prescription drugs for subsequent administration is 'dispensing.'

(7) 'Drug' means:

a. any article recognized as a drug in the United States Pharmacopeia, or in any other drug compendium or any supplement thereto, or an article recognized as a drug by the United States Food and Drug Administration;
b. any article, other than food or devices, intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in man or other animals;
c. any article, other than food or devices, intended to affect the structure or any function of the body of man or other animals; and,
d. any article intended for use as a component of any articles specified in clause a., b. or c. of this subsection.

(8) 'Emancipated minor' means any person under the age of 18 who is or has been married or who is or has been a parent; or whose parents or guardians have surrendered their rights to the minor's services and earnings as well as their right to custody and control of the minor's person; or who has been emancipated by an appropriate court order.

(9) 'Health care provider' means any licensed health care professional; any agent or employee of any health care institution, health care insurer, health care professional school; or a member of any allied health profession.

(10) 'Label' means a display of written, printed or graphic matter upon the immediate or outside container of any drug.

(11) 'Labeling' means preparing and affixing a label to any drug container, exclusive of labeling by a manufacturer, packer or distributor of a nonprescription drug or a commercially packaged prescription drug or device.

(continued on page 6)

PRACTICE ACT

(12) 'License' means a license to practice pharmacy including a renewal license issued by the board.

(13) 'Permit' means a permit to operate a pharmacy or dispense devices, including a renewal license issued by the board.

(14) 'Person' means an individual, corporation, partnership, association, unit of government, or other legal entity.

(15) 'Person in loco parentis' means the person who has assumed parental responsibilities for a child.

(16) 'Pharmacist' means a person licensed under this Article to practice pharmacy.

(17) 'Pharmacy' means any place where prescription drugs are dispensed or compounded.

(18) 'Practice of pharmacy' means the responsibility for interpreting and evaluating drug orders, including prescription orders; compounding, dispensing and labeling prescription drugs and devices; properly and safely storing drugs and devices; maintaining proper records; and controlling pharmacy goods and services. A pharmacist may advise and educate patients and health care providers concerning therapeutic values, content, uses and significant problems of drugs and devices; assess, record and report adverse drug and device reactions; take and record patient histories relating to drug and device therapy; monitor, record and report drug therapy and device usage; perform drug utilization reviews; and participate in drug and drug source selection and device and device source selection as provided in G.S. 90-59. A licensed pharmacist who has received special training may be authorized and permitted to administer drugs pursuant to a specific prescription order in accordance with rules and regulations adopted by each of the Boards of Pharmacy, the Board of Nursing, and the Board of Medical Examiners of the State of North Carolina. Such rules and regulations shall be designed to ensure the safety and health of the patients for whom such drugs are administered.

(19) 'Prescription drug' means a drug that under federal law is required, prior to being dispensed or delivered, to be labeled with the following statement:

'Caution: Federal law prohibits dispensing without prescription.'

(20) 'Prescription order' means a written or verbal order for a prescription drug, prescription device, or pharmaceutical service from a person authorized by law to prescribe such drug, device, or service. A prescription order includes an order entered in a chart or other medical record of a patient.

(21) 'Unit dose medication system' means a system in which each dose of medication is individually packaged in a properly sealed and properly labeled container.

"§ 90-55. *North Carolina Pharmaceutical Association.*—The North Carolina Pharmaceutical Association, and the persons composing it, shall continue to be a body politic and corporate under the name and style of the North Carolina Pharmaceutical Association, and by that name have the right to sue and be sued, to plead and be impleaded, to purchase and hold real estate and grant the same, to have and to use a common seal, and to do any other things and perform any other acts as appertain to bodies corporate and politic not inconsistent with the Constitution and laws of the State.

"§ 90-55.1. *Objective of Pharmaceutical Association*—The objective of the Association is to unite the pharmacists of this State for mutual aid, encouragement, and improvement; to encourage scientific research, develop pharmaceutical talent and to elevate the standard of professional thought.

"§ 90-56. *Board of Pharmacy; creation; membership; qualification of members.*—(a) Creation. The responsibility for enforcing the provisions of this Article and the laws pertaining to the distribution and use of drugs is vested in the board. The board shall adopt reasonable rules for the performance of its duties. The board shall have all of the duties, powers and authorities specifically granted by and necessary for the enforcement of this Article, as well as any other duties, powers and authorities that may be granted from time to time by other appropriate statutes.

(b) Membership. The board shall consist of **six members, one of whom shall be a representative of the public,** and the remainder of whom shall be pharmacists.

(c) **Qualifications. The public member of the board shall not be a health care provider or the spouse of a health care provider. He shall not be enrolled in a program to prepare him to be a health care provider. The public member of the board shall be a resident of this State at the time of his appointment and while serving as a board member.** The pharmacist members of the board shall be residents of this State at the time of their appointment and while serving as board members.

"§ 90-56.1. *Board of Pharmacy; selection; vacancies; commission; term; removal.*—(a) The Board of Pharmacy shall consist of six persons. Five of the members shall be licensed as pharmacists within this State and shall be elected and commissioned by the Governor as hereinafter provided. Pharmacist members shall be chosen in an election held as hereinafter provided in which every person licensed to practice pharmacy in North Carolina and residing in North Carolina shall be entitled to vote. **Each pharmacist member of said Board shall be elected for a term of three years** and until his successor shall be elected and shall qualify. Members chosen by election under this section shall be elected upon the expiration of the respective terms of the members of the present Board of Pharmacy. No pharmacist shall be nominated for membership on said Board, or shall be elected to membership on said Board, unless, at the time of such nomination, and at the time of such election, he is licensed to practice pharmacy in North Carolina. In case of death, resignation or removal from the State of any pharmacist member of said Board, the pharmacist members of the Board shall elect in his place a pharmacist who meets the criteria set forth in this section to fill the unexpired term.

One member of the Board shall be a person who is not a pharmacist and who represents the interest of the public at large. The Governor shall appoint this member.

All Board members serving on June 30, 1981, shall be eligible to complete their respective terms. **No member appointed or elected to a term on or after July 1, 1981, shall serve more than two complete consecutive three-year terms.** The Governor may remove any member appointed by him for good cause shown and may appoint persons to fill unexpired terms of members appointed by him.

It shall be the duty of a member of the Board of Pharmacy, within 10 days after receipt of notification of his appointment and commission, to appear before the clerk of the superior court of the county in which he resides and take and subscribe an oath to properly and faithfully discharge the duties of his office according to law.

(b) **All nominations and elections of pharmacist members of the Board shall be conducted by the Board of Pharmacy, which is hereby constituted a Board of Pharmacy elections. Every pharmacist with a current North Carolina license residing in this State shall be eligible to vote in all elections. The list of pharmacists shall constitute the registration list for elections. The Board of Pharmacy Elections is authorized to make rules and regulations relative to the conduct of these elections, provided such rules and regulations are not in conflict with the provisions of this section and provided that notice shall be given to all pharmacists residing in North Carolina. All such rules and regulations shall be adopted subject to the procedures of Chapter 150A of the General Statutes of North Carolina. From any decisitn of the Board of Pharmacy Elections relative to the conduct of such elections, appeal may be taken to the courts in the manner otherwise provided by Chapter 150A of the General Statutes.**

(c) All rules, regulations, and bylaws of the North Carolina Board of Pharmacy so far as they are not inconsistent with the provisions of this Article, shall continue in effect.

"§ 90-56.2 *Organization*—The board shall elect from its members a president, vice-president, and other officers as it deems necessary. The officers shall serve one-year terms and until their successors have been elected and qualified.

"§ 90-56.3. *Meetings.*—The board shall meet at least twice annually for the purpose of administering examinations and conducting other business. Four board members constitute a quorum. The board shall keep a record of its proceedings, a register of all licensed persons, and a register of all persons to whom permits have been issued. The board shall report, in writing, annually to the Governor and the presiding officer of each house of the General Assembly.

(continued on page 11)

Perspectives in Pharmacy

Patient Drug Information

Presented in the interest of better-informed pharmacy

Neil L. Pruitt, R.Ph.
President
National Association of Retail Druggists

"The delivery of health care in our communities is changing. Traditional institutions are giving way to home health care and outpatient clinics. Handicapped persons with their special needs for durable medical equipment and health supports and appliances require personal attention. The increase in over-the-counter products that were once prescription-only means that more customers will require counseling on their use. An increasing drug-dependent elderly population will rely more than ever on the professional advice of their pharmacists.

"Patient counseling will become more important than ever before because of the hosts of different populations we are seeing in our stores—the handicapped, the elderly, the teenager who has more money to spend on cosmetics, the consumer who wants to know about the efficacy of the drugs he or she is taking.

"Talking to our customers gives us a unique marketing advantage because we know who they are and what they want. Service is, indeed, one of our keys for survival."

Neil L. Pruitt, R.Ph.

Dorothy L. Smith, Pharm.D.
Director of Clinical Affairs
American Pharmaceutical Association

"The pharmacist has an excellent opportunity to test the patient's recall of the information provided by the physician, to make the prescription instructions readily understandable, and to reinforce the patient's faith in the prescribed therapy.

Dorothy L. Smith, Pharm.D.

"The type and amount of information required will vary with the specific needs of the patient. But generally, patients want enough information to help them complete the therapy *as easily* and *as safely* as possible.

"Almost all patients will have questions about applying the drug regimen to their own schedules. They are willing to modify their daily activities to accommodate a dosage schedule if they understand why the changes are best for them. But these questions can be answered only on an individual basis.

"Handing the patient a full disclosure sheet does not effectively help 'educate.' In fact, a long list of potential adverse effects may even convince a patient *not* to take the medication.

"Every effort must be made not to frighten the patient. Basically, the role of the pharmacist is to help a patient use drugs most effectively and with the least anxiety."

Reprinted from American Pharmacy, Vol. NS 21, No. 7, p. 382.

John F. Schlegel, Pharm.D., M.S. Executive Director American Association of Colleges of Pharmacy

"Most pharmacy professionals recognize the importance of communication skills. Indeed, depending on one's particular perspective, personal pharmacy service that emphasizes patient education can be a source of immense satisfaction, enhanced professional image, increased patronage, and improved health care through better understanding and use of medicines.

"Influences both inside and outside the profession point toward a resurgence of personal contact between the pharmacist and the patient. The public's 'right to know' cannot responsibly be denied. The problem has been in finding time in the pharmacy student's busy curriculum for proper communication skills training.

John F. Schlegel, Pharm.D., M.S.

"For the past several years, colleges of pharmacy have been increasing the quantity and quality of training in this area, and greater attention is being paid to the influence of personality types on professional motivation.

"In the future, the 1980's will likely be described as the 'Communications Era' in pharmacy. The profession has made significant advances, but there is still a need for more change."

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Indianapolis, Indiana 46285

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PRACTICE ACT

"§ 90-56.4. *Employees; Executive Director.*—The board shall employ as **Executive Director** a pharmacist to serve as a full-time employee of the board. The Executive Director shall serve as Secretary and Treasurer of the board and shall perform administrative functions as authorized by the board. The board shall have the authority to employ other personnel as it may deem necessary to carry out the requirements of this Article.

"§ 90-56.5. *Compensation.*—The board shall determine the compensation of its employees. Employees shall be reimbursed for all necessary expenses incurred in the performance of their official duties.

"§ 90-56.6. *Executive Director to make investigations and prosecute.*—(a) Upon receiving information concerning a violation of this Article, the Executive Director shall promptly conduct an investigation and if he finds evidence of the violation, he may file a complaint and prosecute the offender in a board hearing.

(b) In all prosecutions of unlicensed persons for the violation of any of the provisions of this Article, a certificate signed under oath by the Executive Director shall be competent and admissible evidence in any court of this State that the person is not licensed, as required by law.

"§ 90-56.7. *Approval of schools and colleges of pharmacy.*—The board shall approve schools and colleges of pharmacy upon a finding that students successfully completing the course of study offered by the school or college can reasonably be expected to practice pharmacy safely and properly.

"§ 90-56.8 *Practical experience program.*—The board shall issue regulations governing a practical experience program. These regulations shall assure that the person successfully completing the program will have gained practical experience that will enable him to safely and properly practice pharmacy.

"§ 90-56.9 *Application and examination for licensure as a pharmacist; prerequisites.*—(a) Any person who desires to be licensed as a pharmacist shall file an application with the Executive Director on the form furnished by the board, verified under oath, setting forth the applicant's name, age, the place at which and the time that he has spent in the study of pharmacy, and his experience in compounding and dispensing prescriptions under the supervision of a pharmacist. The applicant shall also appear at a time and place designated by the board and submit to an examination as to his qualifications for being licensed. The applicant must demonstrate to the board his physical and mental competency to practice pharmacy.

(b) **On or after July 1, 1982, all applicants shall have received an undergraduate degree from a school of pharmacy approved by the board.** Applicants shall be required to have had up to one year of experience, approved by the board, under the supervision of a pharmacist and shall pass the required examination offered by the board. Upon completing these requirements and upon paying the required fee, the applicant shall be licensed.

"§ 90-56.10. *Examination.*—The license examination shall be given by the board at least twice each year. The board shall determine the subject matter of each examination and the place, time and date for administering the examination. The board shall also determine which persons have passed the examination. The examination shall be designed to determine which applicants can reasonably be expected to safely and properly practice pharmacy.

"§ 90-56.11. *License renewal.*—In accordance with board regulations, each license to practice pharmacy shall expire on December 31 and shall be renewed annually by filing with the board on or after December 1 an application for license renewal furnished by the board, accompanied by the required fee. It shall be unlawful to practice pharmacy more than 60 days after **the expiration date without renewing the license. All licensees shall give the board notice of a change of mailing address or a change of place of employment within 30 days after the change. The board may require licensees to obtain up to 10 hours of continuing education from board-approved providers as a condition of license renewal.**

"§ 90-56.12. Approval of continuing education programs.—The board shall approve providers of continuing education programs upon finding that the provider is competent to and does offer an educational experience designed to enable those who successfully complete the program to more safely and properly practice pharmacy.

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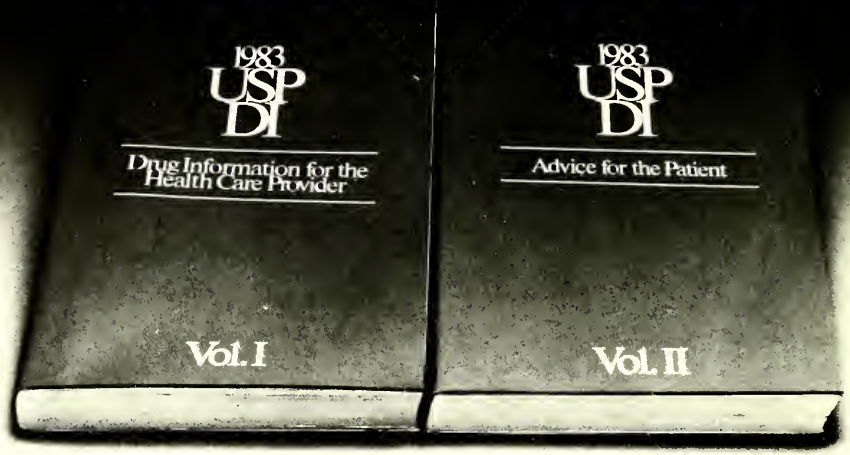
SEPARATE BUT EQUALLY INDISPENSABLE.



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PRACTICE ACT

"§ 90-56.13. Reinstatement.—Whenever a pharmacist who has not renewed his license for five or more years seeks to renew or reinstate his license, he must appear before the board and submit evidence that he can safely and properly practice pharmacy.

"§ 90-56.14. *Licensure without examination.*—(a) The board may issue a licensure to practice pharmacy, without examination, to any person who is licensed as a pharmacist in another jurisdiction if the applicant shall present satisfactory evidence of possessing the same qualifications as are required of licensees in this State, that he was licensed by examination in such other jurisdiction, and that the standard of competence required by such other jurisdiction is substantially equivalent to that of this State at that time. The board must be satisfied that a candidate for licensure has a satisfactory understanding of the laws governing the practice of pharmacy and distribution of drugs in this State.

(b) An applicant who has taken and failed to pass an examination for licensure in North Carolina after July 1, 1977, shall not be granted reciprocal licensure in this State until having completed at least five years of the practice of pharmacy in another state.

"§ 90-56.15. *Pharmacy permit.*—In accordance with board regulations, each pharmacy in North Carolina shall annually register with the board on a form provided by the board. The application shall identify the pharmacist-manager of the pharmacy and all pharmacist personnel employed in the pharmacy. **All pharmacist-managers shall notify the board of any change in pharmacist personnel within 30 days of such change.**

"§ 90-56.16. *Devices; registration.*—**Each place where devices are dispensed shall register annually with the board on a form provided by the board; provided this section shall not apply to places with current pharmacy permits. Records of devices dispensed in pharmacies or other places shall be kept in accordance with regulations promulgated by the Board of Pharmacy.**

"§ 90-56.17. *License/permit to be displayed.*–**Every pharmacist-manager's license, every permit, and every current renewal shall be conspicuously posted in the place of business owned by or employing the person to whom it is issued. The licenses and every last renewal of all other pharmacists employed in the pharmacy must be readily available for inspection by agents of the board.** Failure to display any license or permit and the most recent renewal shall be a violation of this Article and each day that the license or permit or renewal is not displayed shall be a separate and distinct offense.

"§ 90-57. *Disaster reports.*—**The pharmacist in charge of a pharmacy shall report within 10 days to the board any disaster, accident, theft, or emergency which may affect the strength, purity, or labeling of drugs and devices in the pharmacy.**

"§ 90-58. *Prescription orders preserved.*—Every pharmacist-manager of a pharmacy shall maintain for **at least three years** the original of every prescription order and refill compounded or dispensed at the pharmacy except for prescription orders recorded in a patient's medical record. **An automated data processing system may be used for the storage and retrieval of refill information for prescriptions pursuant to the regulations of the board.**

"§ 90-60. *Filling/refilling regulations.*—The board may promulgate rules governing the filling, refilling and transfer of prescription orders not inconsistent with other provisions of law regarding the distribution of drugs and devices. Such regulations shall assure the safe and secure distribution of drugs and devices. **Prescriptions marked PRN shall not be refilled more than one year after the date issued by the prescriber unless otherwise specified.**

"§ 90-61. *Unit dose medication systems.*—**The board may adopt regulations governing pharmacists providing unit dose medication systems. The regulations shall ensure the safe and proper distribution of drugs in the patient's best health interests.**

"§ 90-62. *Unique pharmacy practice.*—**Consistent with the provisions of this Article, the board may regulate unique pharmacy practices including, but not limited to, nuclear pharmacy and clinical pharmacy, to ensure the best interests of patient health and safety.**

"§ 90-63. *Availability of patient records.*—**Pharmacists employed in health care**

(continued on page 14)

PRACTICE ACT

facilities shall have access to patient records maintained by those facilities when necessary for the pharmacist to provide pharmaceutical services. The pharmacist shall make appropriate entries in patient records.

"§ 90-64. Availability of pharmacy records.—(a) Except as provided in subsections (b) and (c) below, written prescription orders on file in a pharmacy are not public records and any person having custody of or access to the prescription orders may divulge the contents or provide a copy only to the following persons:

(1) An adult patient for whom the prescription was issued or a person who is legally appointed guardian of that person;
(2) An emancipated minor patient for whom the prescription order was issued or a person who is the legally appointed guardian of that patient;
(3) An unemancipated minor patient for whom the prescription order was issued when the minor's consent is sufficient to authorize treatment of the condition for which the prescription was issued;
(4) A parent or person in loco parentis of an unemancipated minor patient for whom the prescription order was issued when the minor's consent is not sufficient to authorize treatment for the condition for which the prescription is issued.
(5) The licensed practitioner who issued the prescription;
(6) The licensed practitioner who is treating the patient for whom the prescription was issued;
(7) A pharmacist who is providing pharmacy services to the patient for whom the prescription was issued;
(8) Anyone who presents a written authorization for the release of pharmacy information signed by the patient or his legal representative;
(9) Any person authorized by subpoena, court order or statute;
(10) Any firm, association, partnership, business trust, corporation or company charged by law or by contract with the responsibility of providing for or paying for medical care for the patient for whom the prescription order was issued;
(11) A member or designated employee of the board;
(12) The executor, administrator or spouse of a deceased patient for whom the prescription order was issued;
(13) Researchers and surveyors who have approval from the board. The board shall issue this approval when it determines that there are adequate safeguards to protect the confidentiality of the information contained in the prescription orders and that the researchers or surveyors will not publicly disclose any information that identifies any person; or
(14) The person owning the pharmacy or his authorized agent.

(b) A pharmacist may disclose any information to any person only when he reasonably determines that the disclosure is necessary to protect the life or health of any person.

(c) Records required to be kept by G.S. 90-93(d) (Schedule V) are not public records and shall be disclosed at the pharmacist's discretion.

"§ 90-65. Embargo.—Notwithstanding any other provisions of law, whenever an authorized representative of the board has reasonable cause to believe that any drug or device presents a danger to the public health, he shall affix to the drug or device a notice that the article is suspected of being dangerous to the public health and warning all persons not to remove or dispose of the article. Whenever an authorized representative of the board has reasonable cause to believe that any drug or device presents a danger to the public health and that there are reasonable grounds to believe that it might be disposed of pending a judicial resolution of the matter, he shall seize the article and take it to a safe and secure place. When an article has been embargoed

under this section, the board shall, as soon as practical, file a petition in Orange County District Court for a condemnation order for such article. If the judge determines after a hearing, that the article is not dangerous to the public health, the board shall direct the immediate removal of the tag or other marking, and where appropriate, shall direct that the article be returned to its owner. If the judge finds the article is dangerous to the public health, he shall order its destruction at the owner's expense and under the board's supervision. If the judge determines that the article is dangerous to the public health, he shall order the owner of the article to pay all court costs, reasonable attorney's fees, storage fees, and all other costs incident to the proceeding.

"§ 90-66. *Disciplinary authority.*—(a) The board may, in accordance with Chapter 150A of the General Statutes, issue a letter of reprimand or suspend, restrict, revoke, or refuse to grant or renew a license to practice pharmacy, or require licensees to successfully complete remedial education if the licensee has:

(1) made false representations or withheld material information in connection with securing a license or permit;
(2) been found guilty of or plead guilty or nolo contendre to any felony in connection with the practice of pharmacy or the distribution of drugs;
(3) indulged in the use of drugs to an extent that renders him unfit to practice pharmacy;
(4) made false representations in connection with the practice of pharmacy that endanger or are likely to endanger the health or safety of the public, or that defraud any person;
(5) a physical or mental disability that renders him unfit to practice pharmacy with reasonable skill, competence and safety to the public;
(6) failed to comply with the laws governing the practice of pharmacy and the distribution of drugs;
(7) failed to comply with the rules and regulations of the board;
(8) engaged in, or aided and abetted an individual to engage in, the practice of pharmacy without a license; or
(9) was negligent in the practice of pharmacy.

(b) The board, in accordance with Chapter 150A of the General Statutes, may suspend, revoke, or refuse to grant or renew any permit for the same conduct as stated in subsection (a).

(c) Any license or permit obtained through false representation or withholding of material information shall be void and of no effect.

"§ 90-67. *Injunctive authority.*—The board may apply to any court for an injunction to prevent violations of this Article or of any rules enacted pursuant to it. The court is empowered to grant the injunctions regardless of whether criminal prosecution or other action has been or may be instituted as a result of the violation.

"§ 90-68. *Violations.*—(a) It shall be unlawful for any owner or manager of a pharmacy or other place to allow or cause anyone other than a pharmacist to dispense or compound any prescription drug except as an aide to and under supervision of a pharmacist.

(b) Every person lawfully authorized to compound or dispense prescription drugs shall comply with all the laws and regulations governing the labeling and packaging of such drugs by pharmacists.

(c) It shall be unlawful for any person not licensed as a pharmacist to compound or dispense any prescription drug, except as an aide to and under the supervision of a pharmacist.

(d) It shall be unlawful for any person to manage any place of business where devices are dispensed or sold at retail without a permit as required by this Article.

(e) It shall be unlawful for any person without legal authorization to dispose of an article that has been embargoed under this Article.

(f) It shall be unlawful to violate any provision of this Article or of any rules or regulations enacted pursuant to it.

(g) This Article shall not be construed to prohibit any person from performing an act that person is authorized to perform pursuant to North Carolina law. Health care providers who are

(Continued on Page 35)

P.D., Pharm.D., or Ph.D.
Will the *Real Doctor* Please Stand Up

William T. Sawyer, M.S.

Recent proposals for adoption of the P. D. designation by pharmacy practitioners in several states have generated considerable controversy. Unfortunately, this issue, as others, has succeeded in pitting particular groups within the profession against one another. In the case of the P. D. designation, it appears that academia has been pitted against the practice community, and within the later group, hospital pharmacists against community pharmacists. What is on the surface primarily a semantic issue actually reflects much deeper concerns within the profession about titles, designations, degrees, competence, professional recognition, and public respect. All too often, however, proponents and antagonists have engaged in debates where there is no genuine exchange of ideas but, rather, espousals of philosophy without regard to opposing points of view. The recent session of the North Carolina Pharmaceutical Association Convention, during which the P. D. designation was adopted, is an excellent illustration of this controversy. Since it is difficult for issues to be rationally and objectively examined during an emotional debate, it seems more appropriate at this time to attempt to clarify some of the concerns of the different groups.

An Academic Perspective

The pharmacy academician may view the P. D. designation as a fraudulent method of obtaining the title "Doctor" for/by pharmacists who are unwilling or intellectually unable to achieve this title by traditional means (formal degree-granting programs). Although the P. D. is described as a professional designation and not an academic degree, the academic community may still view it as a degree obtained without any work. It may therefore be seen as professionally, scientifically and academically dishonest by faculty members. Schools of pharmacy deal with degrees, and award those degrees on the basis of tangible, measurable evidence of performance. The subtle differences between degrees and designations may not be perceptible, therefore, in the academic environment.

There are several interesting similarities between the P. D. issue and the controversy which arose earlier when the Pharm.D. degree began to gain wide-spread acceptance. Among some members of the Ph.D. community, the Pharm.D. was regarded as something other than a "real" doctoral degree, and holders of the Pharm.D. degrees were viewed with scorn, scientific snobbery, and probably a small element of fear. No longer was the title "Doctor" reserved for those who had labored long and hard in the laboratories as impoverished graduate students. These upstart clinical pharmacists were now assuming the title "Doctor" by completing a shorter training program, perceived to be less scientifically rigorous. Presently, the P. D. designation is fostering similar resentments, in particular among holders of the Pharm.D. degree. At a time when the Pharm.D. practitioners are fighting a very tough, prolonged battle to achieve professional respect in the clinical arena (very often from physicians who believe that the only "real" doctor is an M.D.), adoption of the P. D. designation is seen as an action that will only undermine the credibility of the Pharm.D. practitioner and the profession of pharmacy in the eyes of other health professionals, particularly physicians. Certainly, the issues that concerned Ph.D.-level faculty about the Pharm.D. degree are magnified many fold by the P. D. designation.

At the same time, interestingly enough, a number of hospital pharmacists appear to be antagonistic to the P. D. designation as well. This may reflect the fact that the majority of Pharm.D. holders are engaged in clinical practice in the institutional setting. There seem to be strong links between hospital pharmacy practice and academia, and these groups may share similar concerns about the P. D. designation.

A Practice Perspective

From the practitioner's viewpoint, there are equally valid arguments in favor of the P. D. designation. Traditionally, the title "Doctor" or "Doc" has been informally accorded to the community pharmacy practitioner by those individuals whose respect the pharmacist feels is most important, patients. Pharmacy, unfortunately, is one of the few professions (with nursing)

in which the entry level degree is not a doctorate. In addition, until the past decade, a *professional* doctoral program was not even available to most pharmacists ready to enter practice. The pharmacy practitioner, particularly the community setting, may now understandably view the increasing number of Pharm.D. degree graduates with some suspicion. After all, here are practitioners who call themselves 'Doctor' (and may in some cases act as if the community pharmacist is some sort of professional inferior), but seem somewhat uninterested in community pharmacy practice. These new "clinical" types seem no better able to function in the community setting than B.S. degree practitioners (if even as well). At the same time, the academic pharmacy community has made little provision for allowing practicing pharmacists to upgrade their skills and earn a doctoral degree, without giving up an established practice, family responsibilities, etc. It may even appear to practitioners that schools of pharmacy are intent on training a new breed of pharmacists with different skills (or at least a different title) who will ultimately make the present practitioner obsolete, while neglecting to offer that present practitioner, who has been carrying the professional banner for pharmacy for years, an opportunity to participate in this new professional glory. The negative reaction of the academic community to the P. D. designation is seen as another sign that academic pharmacy is out of touch with the real world of pharmacy practice. This feeling may be enhanced by the fact that many pharmacy faculty members are not presently, or have never been, practicing pharmacists. Considering these circumstances, is it surprising that practicing pharmacists may feel that the P. D. designation issue is "none of academia's business?"

In this state, practicing pharmacists may also see the adoption of P. D. designation by associations and organizations in surrounding states as an additional potential threat to their own practice. Practitioners who relocate here from surrounding areas could conceivably display a certificate proclaiming their P. D. designation, while practitioners from this state were theretofore unable to do so. Patients who enter the community pharmacy may not understand the professional and practical differences and insist on speaking with the "real Doctor." It is important to recognize, as previously mentioned, that the community practitioner looks to the patient as the provider of professional respect, and not necessarily to other health professionals. The practitioner also looks to the patient for economic respect, and the 'real Doctor' may be worth more.

Who Is Right?

Certainly, both points of view have some merit, and should be objectively and fairly considered. The disagreement over the P. D. designation reflects more a failure of communication between divergent groups of pharmacists, with different interests and motivations, than absolute degrees of right or wrong. All too often, it is easy for the academic pharmacist to view the practitioner with intellectual scorn while the practicing pharmacist looks at the academic as a pointy-headed idealist, isolated within the ivory tower. It is hard to view this situation without some degree of concern, as well as amusement. Academic pharmacy faculty, hospital pharmacy practitioners, community pharmacists, pharmacy researchers, etc. all contribute to the profession of pharmacy in different but important ways. To suggest that one group is more valuable or vital than another to our profession is somewhat ridiculous. A continuation of the present unfortunate state of affairs will only result in damage to the profession, rather than a 'victory' for any point of view. In pharmacy, we are walking a tightrope as we attempt to progress toward the goals of professional acceptance by other health care providers as well as patients, and the privilege to practice our profession in the fashion we are trained. In a time of fiscal constraints, our attempts to carve out expanded professional roles may provoke economic concerns and therefore professional resistance, among other health care providers. If various segments within our profession continue to fight among themselves over issues such as adoption of the P. D. designation, the inevitable result is that we will fall off the tightrope into the abyss of professional oblivion.

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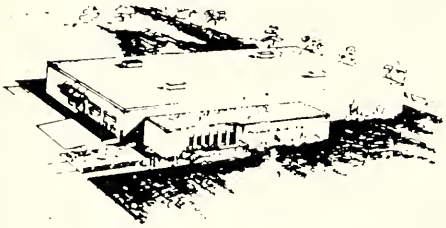

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TO: **Pharmacists/Pharmacies Participating in the Programs of the North Carolina Division of Health Services**

FROM: **Ray Shackelford**
Provider Relations Manager
Office of Purchase-of-Care Services

Effective July 1, 1982, the N. C. Division of Health Services will reimburse providers of pharmacy services at the Medicaid rate of reimbursement. The *1981 Session Laws,* Chapter 859, Section 17 requires that providers of medical and medically related services under the various State programs other than Medicaid shall be reimbursed at rates no more than those under the Medicaid program. This requirement pertains to payments made under the following programs:

1. Crippled Children's Program
2. State Kidney Program
3. Sickle Cell Program
4. Migrant Health Program
5. Any other health care program of the Division of Health Services

In order to facilitate compliance with this requirement and to provide uniformity in billing practices under the programs of the Division of Health Services, a common pharmacy claim has been developed for your use. A facsimile of the multi-part form, DHS 3058, is attached for your information. Instructions for completing the form are on its reverse. Please read them carefully.

A supply of the form will be mailed to you as soon as possible. If you do not receive copies by the time you are ready to bill for drugs *dispensed in July, 1982,* please order forms from the Mailing Unit, N. C. Division of Health Services, Post Office Box 2091, Raleigh, NC 27602.

Billing rules for providers of health care services to clients of the Division's programs are set forth in the North Carolina Administrative Code, 10 NCAC 4C, .0302. The following billing regulations govern payments for pharmacy services:

1. If no other third party payor is involved, a claim for payment must be submitted to the Division within 60 days after the date of completion of the authorized services, or within 30 days after the date of authorization approval by the Division, whichever is later.
2. If third parties are billed, the claim shall include an accounting of third party payments, denials of payment, and the status of pending third party claims.
3. Failure to provide a claim for payment in accordance with these provisions shall result in denial of payment.
4. The Division shall make payment to the provider within 45 days after receipt of a claim for payment for authorized services.
5. Requests for authorization and claims for payment for inpatient, outpatient, physician, dental, and pharmacy services shall be submitted on forms provided by the Division at its principal address.

Also, please note the "TERMS AND CONDITIONS" on the reverse of the claim, DHS 3058, to which you agree when signing the front of the form.

For clients of the *State Kidney Program,* please note that the reimbursement limitation of $25.00 per month per patient is still in effect. This amount includes the Medicaid dispensing free of $2.80 per prescription per month. When filing prescription claims for clients of the Kidney Program, be sure to bill for the full amount of all prescriptions rather than limit your charge to $25.00 since the Medicaid-pricing of the claim may result in payment of less than $25.00 on a charge of $25.00.

For clients of the *Migrant Health Program* and *School Health Fund,* please route your claim through the local health department which authorized the service. The health department will mail the claim to the Division for pricing.

If you have questions, please contact me at 919/733-3131 or Charles Reed, Pharmacist, at 919/733-7081 or write either of us at the N. C. Division of Health Services, P. O. Box 2091, Raleigh, NC 27602.

June, 1982

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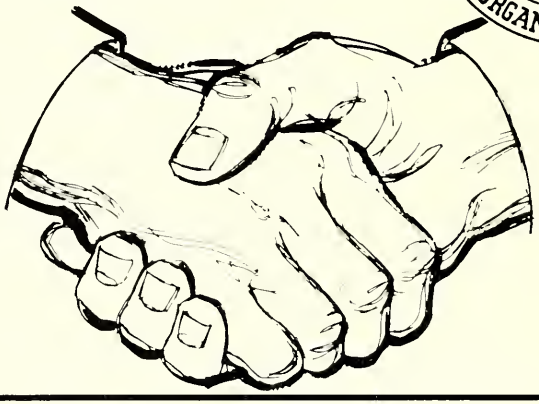

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1982-83 TMA Officers, installed at the Annual Convention, Winston-Salem, April 6. Left to right: David F. McGowan, Asst. Sec-Treas.; L. M. McCombs, Sec. Treas.; W. C. Warren, 2nd Vice President; Roy M. Moss, 1st Vice President; C. Rush (Rusty) Hamrick, III, President. (Photo by Colorcraft)

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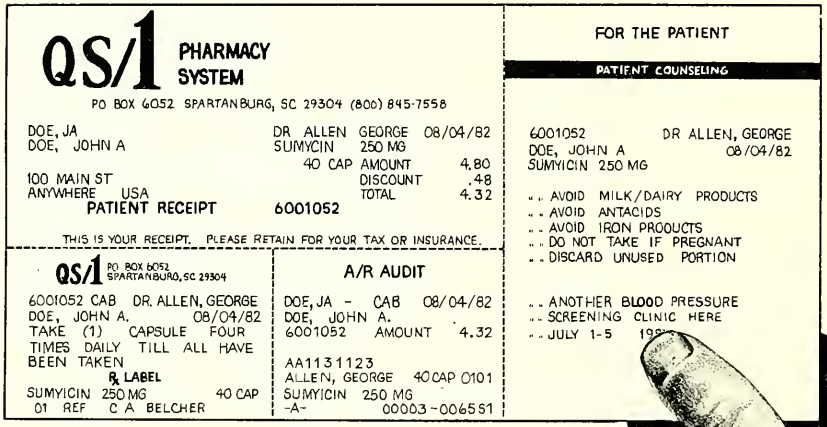

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LOCAL NEWS

WAKE COUNTY PHARMACEUTICAL ASSOCIATION

Tuesday night, May 4th, the program "Computers in Community Pharmacy," was given as a joint effort of the Wake AHEC, WCPhA, and the UNC School of Pharmacy. Frank Yarborough did an excellent job of presenting computer basics from a pharmacist's point of view. This was followed by a demonstration of systems and a review by representatives of TBL, Pharmacon and QS/1. Although it is virtually impossible to cover a topic like this in a short period of time, the effort expended by Frank and the company representatives was enough to wet the appetites of those present. Thanks to all the program participants for such a good job.

A special thanks to the telephone committee who called us all to remind us of upcoming meetings. The committee was: Wes Cotton, Chairman; Larry Bullock; Sarah Clark; Ginger Lockamy; Ken Lowery; Buc Murchison; and Bobby Wheeler.

Kudos to the volunteers in the just completed Health Fair;

North Hills—Wes Cotton, Buc Murchison, Ginger Lockamy, Ken Lowery, Al Lockamy and Sam Scudder.

Cary Village Mall—Ralph Ashworth, Linda Bartrom, Sarah Clark, Peggy Yarborough, William Dupree, Nancy Thigpen, Elizabeth Weaver and David Devine.

Meredith—Wayne Creech and Darrell Estes.

WRAL-TV—Darrell Estes.

ROCKINGHAM COUNTY SOCIETY OF PHARMACISTS

The Rockingham County Society of Pharmacists met in Eden Sunday May 16. Two interim officers were elected; Clayborne Hawkins of Madison Vice-President and W. G. Dudley Jr. Secretary-Treasurer.

Next meeting July 18th with Shelton Brown as guest.

WINDSOR

Ernest Carraway, Jr., Windsor, who has served as fire chief of the Windsor Voluntary Fire Department for the past six months, has been appointed to serve a one year term as a N. C. Fire Commissioner.

Dear PCS Member Pharmacies
In Winston-Salem, NC Area

Inadvertently we conveyed some erroneous information to the North Carolina Pharmaceutical Association announcing a dispensing fee increase for the Winston-Salem Health Care Plan #901, from $2.70 to $3.00. We understand the North Carolina Pharmaceutical Association included this announcement in their last bulletin.

This was an error on our part as the Winston-Salem Health Care Plan #901 dispensing fee is still at $2.70. We apologize for any inconvenience this may have caused you.

Sincerely,
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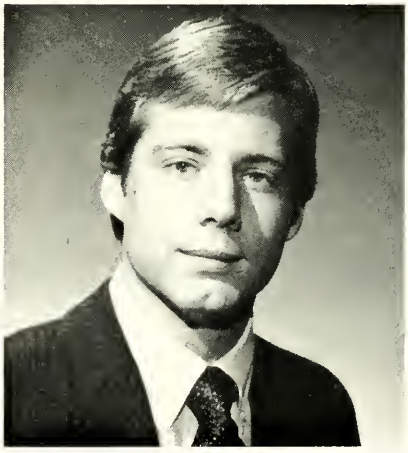

Stephen M. Eudy has been assigned to the Asheville territory for The Upjohn Company. He recently completed four weeks of training at The Upjohn Company Learning Center in Kalamazoo, Michigan. This is part of the ten week initial-phase training for all new Upjohn sales representatives. Steve is a graduate of the University of North Carolina—Chapel Hill.

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NCP 6-82

REPORT OF THE P.D. AD HOC STUDY COMMITTEE

Winston-Salem, North Carolina
April 6, 1982

MEMBERS

H. Shelton Brown, Jr., Chairman, Cary, NC
Jack G. Watts, Burlington, NC
Henry L. Smith, Chapel Hill, NC
Mickey Watts, Concord, NC
William P. Powell, Mars Hill, NC
Walter K. Saunders, Jr., Charlotte, NC

RESOLUTION (Adopted by the NCPhA Convention, April 28, 1981)

Whereas, Pharmacists in North Carolina are licensed and not registered, and the current designation R.Ph. is a misnomer; and

Whereas, A uniform designation for all pharmacists is necessary for natural professional evolution; and

Whereas, There is significant historical precedent for the use of P.D. to designate a person as a pharmacist;

Therefor Be It Resolved: That the matter of P. D. designation for pharmacist be referred to the Executive Committee of the North Carolina Pharmaceutical Association, and the new President form an ad hoc committee to study this.

COMMITTEE

In response to this 1981 resolution, President J. Marshall Sasser named the above NCPhA members of this committee, titled the PD Ad Hoc Study Committee. The committee met at the Institute of Pharmacy in Chapel Hill on Sunday, February 28, 1982 at 2:00 P.M.

Committee members brought to this meeting articles and information relating to the P. D. issue. Included were articles stating the positions of both the APhA and NARD. Each member reviewed the compiled information as well as the presentations at the Socio-Economic Seminar—Pro, Jesse Pike and Con, Frank Yarborough.

After two and one-half hours of discussion and debate the committee had four alternatives:

1) To recommend no action on P. D.
2) To recommend NCPhA adoption of P. D.
3) To recommend NCPhA adoption of P. D. and continuing education
4) To recommend further study of the P. D. issue.

The vote was unanimous to recommend the third alternative. The committee further instructed the chairman to draft a resolution incorporating their decision. Such resolution was subsequently drafted and approved by all members of the P. D. Ad Hoc Study and forwarded to the NCPhA Resolutions Committee.

Respectfully submitted,

H. Shelton Brown, Jr.
Chairman

FAMOUS NCPhA PRESIDENT ZIPCODED

Ernest J. Rabil, NCPhA President, has been zipcoded by an unknown member (?) of the North Carolina Pharmaceutical Association.

An envelope with President Rabil's picture and his zipcode, 27103, but with no name or street address, was delivered by the US Postal Service to the addressee. Inside was a note to the effect "You have now been zipcoded." In Winston-Salem, a town of 131,885 people and at least 9 zipcodes, our president is known by his face and reputation.

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THE FOUNDATION—WHAT IT IS AND WHAT IT MEANS

Tom S. Miya, Dean

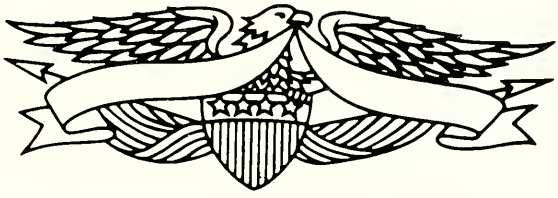
The North Carolina Pharmaceutical Research Foundation will complete its 36th year of operation when its Board of Directors holds its annual meeting on September 8 at The Carolina Inn. The Foundation was legally incorporated on December 17, 1946, as a result of discussions by members of the North Carolina Pharmaceutical Association. The first Board of Directors included names that are familiar to us all—W. A. Gilliam, H. C. McAllister, and W. J. Smith as well as Carl T. Durham, R. A. McDuffie, C. T. Council, P. A. Hayes, P. B. Bissette, I. T. Reamer, E. C. Daniel, A. N. Martin and B. F. Page. The Foundation was established "as an expression of crystallization of the ambitions of the pharmacists of the state and the University authorities" and is the oldest philanthropic foundation designated to assist a specific school of pharmacy.

During the time I have been privileged to serve as its Secretary and ex officio member of the Board of Directors, I have observed the commitment and true dedication of the members of the Board who give so much without compensation. On behalf of the School, I want to thank them all publicly for their service. Heading this group is President Ralph P. Rogers, Jr. and Vice President Edward Brecht (Dean Emeritus).

The Foundation continues to carry "research" in its name, but today it serves a much broader function. True, it continues to foster research, but much of its resources go towards undergraduate student scholarships and for matching funds for federal loans to students. Recognizing this important function, the 1981 entering pharmacy class (third year in college), urged by then president John McCall, contributed 25% of funds from their drive to the Foundation. This year, the same class, now fourth-year students, repeated their contribution. Foundation funds are also used for recruitment of faculty and students and lecture series as well as a number of worthwhile activities. Among the latter category is the assistance it gave recently to the formation of the highly successful UNC Pharmacy Alumni Association and a few years ago the funding of the Health Planning Task Force. The Report of the Task Force findings was recognized nationally and also useful in the development of the proposed Pharmacy Practice Act in North Carolina.

Contributions to the Foundation have now been combined with Carolina Annual Giving, and every alumnus can designate any portion of his/her contribution to the Foundation, all of which counts toward the various giving Clubs, such as the Chancellor's Club.

The Foundation should be looked upon as the margin required for excellence. In the current climate it is the margin for survival. In this regard, we are no different from the University at Chapel Hill whose state appropriation makes up only slightly over 50% of its entire annual budget. For the many who have given, our heartfelt appreciation.



FACULTY NOTES

During the week of April 25, a number of our faculty participated in the 129th annual meeting of the American Pharmaceutical Association. FRED M. ECKEL, Professor and Chairman of the Division of Pharmacy Practice, presented two papers entitled "Implementing Clinical Services in a Community Hospital" and "How Students Can Cope with Stress and Burnout." DR. ABRAHAM G. HARTZEMA, Assistant Professor in the Division of Pharmacy Administration, served as a delegate to the Academy of Pharmaceutical Sciences and presented his paper "Delay in Seeking Medical Care for Rheumatoid Arthritis." DR. WILLIAM WARGIN, Assistant Professor in the Division of Pharmaceutics presented a paper entitled "Kinetics of the Rearrangement of Chlorampherical 3-Monosuccinate" along with DR. DALE WURSTER, Assistant Professor in the Division of Pharmaceutics. DR. WURSTER also moderated the first session of the Basic Pharmaceutics Section which was a presentation of original research papers. Again working with DR. WARGIN, he taught a workshop entitled "Automated Dissolution Testing Using HPLC." STEPHEN M. CAIOLA, Associate Professor in the Division of Pharmacy Practice, taught a workshop on "Patient Education for Pharmacists."

LONI T. GARCIA, Visiting Clinical Instructor in the Division of Pharmacy Practice, attended the Kentucky Society of Hospital Pharmacy in Louisville, Kentucky on May 3-4. She spoke on "Professional Burnout and the Well Being of Pharmacy Practitioners."

DR. DALE E. WURSTER, Assistant Professor in the Division of Pharmaceutics, has co-authored a paper along with Garnet Peck and Dane Kildsig (Faculty members at Purdue University) entitled "A Comparison of the Moisture Absorption-Desorption Properties of Corn Starch, U.S.P., and Directly Comprehensible Starch," in *Drug Development and Industrial Pharmacy, 8,* 1982, pp. 343-354. DR. WURSTER also co-authored the paper "Comparison of Solid-Liquid and Liquid-Liquid Mass Transfer" in *Drug Development and Industrial Pharmacy, 8,* 1982, pp. 293-306.

DR. JAMES SWARBRICK, Professor and Chairman in the Division of Pharmaceutics, has recently co-authored a paper (along with GEOFFREY LEE, a post doctoral fellow at UNC-Chapel Hill and Jeffrey Brom, from the University of Southern California) entitled "Drug Permeation Through Human Skin: I. Effect of Storage Conditions of Skin," *Journal of Investigative Dermatology, 78,* 1982, pp. 63-66. DR. SWARBRICK also received a $35,000 grant from the World Health Organization in Geneva to study the Development of Sustained Release Intramuscular Injection of Dapsone. Recently, he served as External Examiner at the National University of Singapore.

DR. CLAUDE PIANTADOSI, Professor in the Division of Medicinal Chemistry, has co-authored a paper (along with JEFFERSON SURLES, doctoral candidate at the UNC-Chapel Hill School of Pharmacy and Robert Wykle, researcher at Bowman Gray School of Medicine) entitled "Platelet Activating Factor (1-0-Alkyl-2-0-Acetyl-*SN*-glycero-3-phosphocholine): Activity of Analogs Lacking Oxygen at the 2- position," *FEBS Letters, 141 (1),* 1982, pp. 29-32. Additionally, DR. PIANTADOSI was invited by the U. S. Department of Energy's Office of Health and Environmental Research to review research proposals submitted to the department for financial support.

DR. RALPH RAASCH, Assistant Professor in the Division of Pharmacy Practice, spoke on "Nutrition and Cancer: Metabolic Alterations" to the UNC Department of Medicine Grand Rounds on May 6, Greensboro AHEC on May 11, to the UNC School of Public Health Nutrition Update on May 19. DR. RAASCH also spoke to the UNC School of Pharmacy Alumni, Spring Meeting May 22 on the topic of Drugs and Nutrition.

DR. TIMOTHY IVES, Clinical Assistant Professor in the Division of Pharmacy Practice and Family Medicine, was the featured speaker at the Midlands AHEC in Columbia, South Carolina on May 26. He spoke on Pharmacokinetics.

CORRECTION NOTICE

Rite of the Roses printed in the May 1982 issue of THE CAROLINA JOURNAL OF PHARMACY should have read:

David Ramsey Davis, Williamston—July 14, *1981*

Stephen Carroll Morris, Bayboro—May 31, *1981*

DRUG INFORMATION REPORTS*

John Kessler, Pharm D.
Supervisor of Drug Information Services

A CHALLENGE

1. Which of the following drugs should not be taken with food?
   A. Hydrochlorothiazide
   B. Captopril
   C. Ibuprofen
   D. Digoxin
2. Which of the following drugs can change the color of the urine?
   A. Phenazopyridine
   B. Acetylsalicylic Acid
   C. Chlorpromazine
   D. Rifampin
3. Which of the following drugs can be crushed and still retain its pharmaceutical properties?
   A. Theo-dur®
   B. Procan SR®
   C. Dimetapp®
   D. Haldol®
4. Since we all wonder about "Close Encounters," which of the following drugs has been reported to cause visual hallucinations of little green men?
   A. Danazol
   B. Amantadine
   C. Ethacrynic Acid
   D. Naproxen

DISTINGUISHED VISITOR

Dr. Tetsuya Sekiba, Professor of Synthetic Organic Chemistry at the National Toyama Technical College, Toyama, Japan is visiting the School of Pharmacy for six weeks. He is working closely with Dr. K. H. Lee, Professor of Medicinal Chemistry, and observing research in the synthesis and structure activity relationships of naturally occurring anti-cancer agents. He is also considering the possibility of joint research in the future between the School of Pharmacy and the National Toyama Technical College.

In addition to anti-cancer agents, Dr. Sekiba is interested in other chemotherapeutic drugs including anti-inflammatory agents. In Toyama, he is currently working with an investigational anti-fungal drug.

During his United States visit, Dr. Sekiba will also spend several days with Dr. Schneller of the University of South Florida at Tampa. He will then come back to Chapel Hill for another week of research prior to returning to Japan.

According to Dr. Lee, "We have certainly enjoyed Dr. Sekiba's visit and are looking forward to the possibility of future joint efforts in the area of natural products research."

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The wax matrix drug delivery system is a pharmaceutical tablet design where crystals of active drug are evenly dispersed in an inert, insoluble wax core. This type of formulation provides a gradual release of medication into the gut for systemic absorption, thereby minimizing high plasma concentrations of the drug and allowing for a prolonged interval between doses. Historically, early formulations of sustained release tablets were unreliable in the rate of release of active drug. Currently, bioavailability studies and improved tablet design assure the reliability of the dosage form. Patients who are prescribed medications formulated in a wax matrix should be advised that the insoluble wax core may appear in the stool, but that the active drug has been absorbed by the body. Slow K®, Ferro-Gradumet,® Klotrix,® and Procan SR® are a few of the commercial products which utilize a wax matrix core.

Sue Lategan R.Ph,
NCMH Pharmacy

* Adapted from *Current Therapeutic Topics* newsletter of the Department of Pharmacy NCMH

ANSWERS

1. B Captopril. Food can decrease absorption by as much as 30%.
2. A,C,D
   Phenazopyridine—red/orange
   Chlorpromazine—pink to red to brown
   Rifampin—red/orange
3. D Haldol. All the remaining drugs are specially formulated to provide a slow rate of release of active drug.
4. B Armantadine. See *Med J Aus* 1973; 1: 444-5.

ScRipt

Mr. Howard Q. Ferguson, left, receives the UNC School of Pharmacy Distinguished Service Award from Dean Tom S. Miya, at the Awards Program of the school.

Mr. G. T. Cornwell, left, receives the UNC School of Pharmacy Distinguished Service Award from Dean Tom S. Miya, at the Awards Program of the school.

REPORT OF THE ELECTIONS COMMITTEE

The Elections Committee of the NCPhA met Thursday, June 24, 1982, at the Institute of Pharmacy, to open and count the ballots. The results are:

First Vice-President of the NCPhA
(President-Elect)
W. A. West, Roseboro

Second Vice-President of the NCPhA
H. Shelton Brown, Jr., Cary

Third Vice-President of the NCPhA
A. Rowland Strickland, Jr., Stantonsburg

Members of the NCPhA Executive Committee for a one-year term:
Jack L. Alexander, Highlands
W. Keith Elmore, Wilmington
Virginia L. Lockamy, Raleigh

Directors of the N. C. Pharmaceutical Research Foundation:
E. A. Brecht, Chapel Hill
Harold V. Day, Spruce Pine
Jean B. Provo, Raleigh
Frank F. Yarborough, Cary

The committee hereby certifies the above named individuals as having been elected, with installation to follow as directed in respective Constitution and By-Laws.

THE ELECTIONS COMMITTEE
Lloyd M. Senter
Robert L. Smith
Loni T. Garcia
Henry L. Smith
A. H. Mebane, III, Executive Director

DRUG STORE MEDLEY

by Blanche Reavis, retired
Inness Street Drug Co.
Salisbury

Once upon a time, *Ben Gay,* a young man from *Mosco,* met *Bonne Bell* on a *Summer's Eve.* Each *Caress* brought on *Loving Care* and now he really loves and *Pampers* her. At *Ben Gay's* request for her hand, *Father John* gave them *A-200* dollar *Cheque* as a wedding gift, which brought on *Snickers* from the couple.

Mac Factor, a conductor on *Humphries II* train, put them on *Trac II,* which was a *Free Zone* to the *Ivory Coast.* On their arrival at *Glover, Toni* the bell boy, took them inside and, as a *Safe Guard,* took their baggage across the *Halls* directly to their suite.

Scott Tissue, the manager, and his wife, *Lady Clairol,* gave them a *Nice* welcome. In the lounge after dinner, whom should they meet but *Madame C. J. Walker,* their former college math teacher. She was there with a group of students: *Magnesia, Lydia E. Pinkham, Cara Nome, Rose Water, Olive Oil,* and *L'Oreal,* great *Pals* to be with.

All the guests were invited to join in as *Ben Gay* and *Bonne Bell* said their wedding vows out under the *Milky Way,* with an *Icy Cool Sea Breeze* blowing. *Mr. Goodbar* performed the ceremony. *Bonne Bell* looked lovely, wearing a *Lily of the Valley* corsage. An offer of music was a *Life Saver,* so a *Band-Aided Lady Esther* as she sang *Sweet and Low* until *Dawn.*

The years went by and as a *Final Touch,* the couple's happiness was complete when they were blessed with two children, *Baby Ruth* and *Babe Ben,* both delivered by their *Mother's Friend–Dr. Grabow.*

Members of the NCPhA Executive Committee at the Retreat held at Aqueduct Conference Center, outside Chapel Hill. Left to right, Joey Edwards, Ernest Rabil, Dave Claytor and Pam Joyner.

PHARMACEUTICAL MANUFACTURERS PRAISED

A reprint from Private Practice, June 1982

Congratulations to the Pharmaceuticals

It is time to recognize the outstanding work performed by many of the pharmaceutical companies' research departments. The companies' officials and their doctors need a special thank you for their courage and determination to keep up the research work. At times it seems almost impossible to meet all the criteria and delays required to get a new drug available for patient use.

Some of the new drugs now available for patients will make our task of caring for ill patients much easier. The new antiviral drug Zovirax, just released by Burroughs Wellcome Co., is certainly a major breakthrough in the treatment of viral diseases and definitely opens the door for many more useful drugs. The new cardiac drugs, such as Pfizer's Procardia and Merck, Sharp & Dohme's Blocadren, are certainly welcomed by physicians. We have been waiting almost 10 years for the new cardiac drugs.

Regulatory delays

Pfizer's Feldene, a new drug for arthritis, is an example of the delays caused by regulations. Forty foreign markets sold $145 million of Feldene in 1981. Why the delay in letting our patients use this drug?

The future for new drugs is certainly much brighter today than any time in the past 20 years. I hope in time that not only will regulations be changed but also those laws which caused the marked delays in new drugs will be repealed.

There is no substitute for complete freedom in research. The pharmaceutical industry has the ability, as well as the capital, to do the necessary research to answer many of the medical problems facing mankind. But they must be free of controls. I hope the new administration will remove those controls so we can get about the business of healing sick patients who, in the past, were doomed to die.

Supporting effective drugs

As a practicing physician, I have two reasons why I will use a new drug as a prescription and continue to prescribe it. It must be produced by a responsible pharmaceutical company and it must be declared safe and effective in the marketplace. I am sure most private practicing physicians feel as I do.

Once again, congratulations to the pharmaceutical companies for having the courage to keep up this research work when it looked almost impossible to clear the required regulations and get a new drug on the market.

Francis A. Davis, MD
Publisher

The NCPhA Loan Fund and Endowment Fund Committee: Left to Right: Standing, Ralph P. Rogers, Jr., Shelton B. Boyd, G. T. Cornwell, Howard Q. Ferguson, Jack W. Wier, Chair, Don V. Peterson, Jack H. Upton. Seated, Russell Phipps, B. R. Ward, W. J. Smith, Robert F. Hall. Staff Photo

Revised Pharmacy Act

(Continued from Page 15)

authorized to prescribe drugs without supervision are authorized to dispense drugs without supervision.

(h) A violation of this Article shall be a misdemeanor punishable in the discretion of the court."

Sec. 2. G.S. 90-60, as amended by Chapter 72 of the 1981 Session Laws, is recodified as G.S. 90-56.18.

Sec. 3. G.S. 90-76.1 through G.S. 90-76.5 are recodified as G.S. 90-59 through G.S. 90-59.4, respectively.

Sec. 4. G.S. 90-76 is repealed.

Sec. 5. Part 2 of Article 4 of Chapter 90 of the General Statutes is repealed.

Sec. 6. This act shall become effective July 1, 1982.

NOTE: Section 2 and 3 refer to the Drug Product Selection and Board of Pharmacy fee statutes which are not affected.

USE OF APPROVED DRUGS FOR UNLABELED INDICATIONS

The appropriateness or the legality of prescribing approved drugs for uses not included in their official labeling is sometimes a cause of concern and confusion among practitioners.

Under the Federal Food, Drug, and Cosmetic (FD&C) Act, a drug approved for marketing may be labeled, promoted, and advertised by the manufacturer only for those uses for which the drug's safety and effectiveness have been established and which FDA has approved. These are commonly referred to as "approved uses." This means that adequate and well-controlled clinical trials have documented these uses, and the results of the trials have been reviewed and approved by FDA.

The FD&C Act does not, however, limit the manner in which a physician may use an approved drug. Once a product has been approved for marketing, a physician may prescribe it for uses or in treatment regimens or patient populations that are not included in approved labeling. Such "unapproved" or, more precisely, "unlabeled" uses may be appropriate and rational in certain circumstances, and may, in fact, reflect approaches to drug therapy that have been extensively reported in medical literature.

The term "unapproved uses" is, to some extent, misleading. It includes a variety of situations ranging from unstudied to thoroughly investigated drug uses. Valid new uses for drugs already on the market are often first discovered through serendipitous observations and therapeutic innovations, subsequently confirmed by well-planned and executed clinical investigations. Before such advances can be added to the approved labeling, however, data substantiating the effectiveness of a new use or regimen must be submitted by the manufacturer to FDA for evaluation. This may take time and, without the initiative of the drug manufacturer whose product is involved, may never occur. For that reason, accepted medical practice often includes drug use that is not reflected in approved drug labeling.

With respect to its role in medical practice, the package insert is informational only. FDA tries to assure that prescription drug information in the package insert accurately and fully reflects the data on safety and effectiveness on which drug approval is based.

from FDA Drug Bulletin
April 1982

CLASSIFIED ADVERTISING

Classified advertising (single issue insertion) 10 cents a word with a minimum charge of $3.00 per insertion. Payment to accompany order.

Names and addresses will be published unless a box number is requested.

In replying to "blind" ads, address Ad. No., Carolina Journal of Pharmacy, P. O. Box 151, Chapel Hill, N. C. 27514.

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Director—Pharmacy AHEC Program
UNC School of Pharmacy
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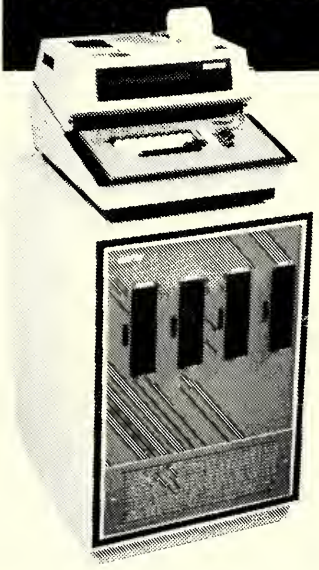

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THE CAROLINA JOURNAL of PHARMACY

JULY/AUGUST 1982 VOLUME 62 NUMBER 7

Rob Bizzell, right, is presented the Don Blanton Award for outstanding service to pharmacy during the past year by immediate past president Marshall Sasser, at the 102 Annual Convention of the North Carolina Pharmaceutical Association in Winston-Salem. Photo by Colorcraft.

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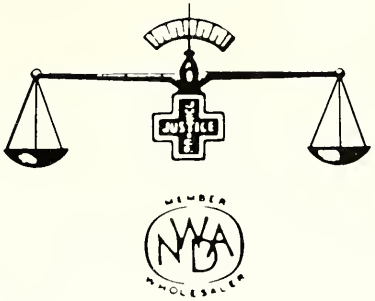

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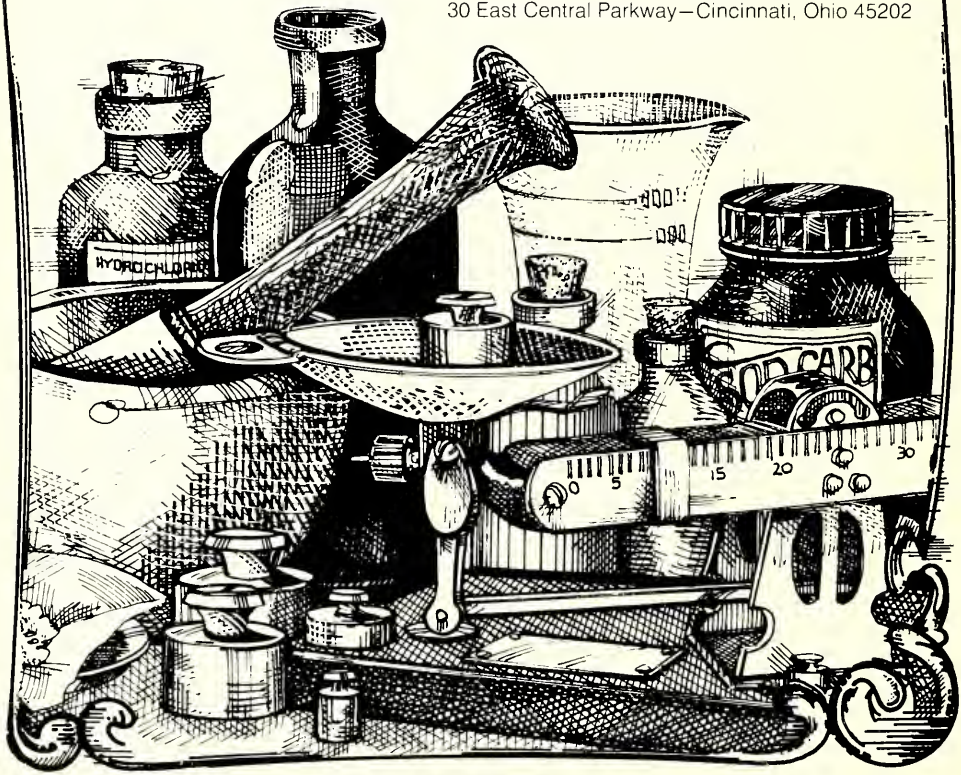

THE CAROLINA
JOURNAL of PHARMACY

(USPS 091-280)
JULY/AUGUST 1982 VOLUME 62 NUMBER 7-8

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RESOLUTIONS
adopted, tabled or defeated by North Carolina Pharmaceutical Association In Convention Assembled
TUESDAY, APRIL 7, 1982
Winston-Salem, NC

RESOLUTIONS COMMITTEE
Albert F. Lockamy, Jr., Chairman, Raleigh
W. Whitaker Moose, Advisor, Mt. Pleasant
Priscilla C. Brown, Germanton
Connie W. McFall, Durham
Prentiss L. George, Jr., Shelby

Resolution No. 1
Short Title: RESOLUTION OF APPRECIATION

WHEREAS: the 1982 Annual Convention of the North Carolina Pharmaceutical Association and Affiliated Auxiliaries, held in Winston-Salem, April 4, 5, & 6, was well planned and executed, and

WHEREAS, it has been an enjoyable, pleasant, and informative meeting for all participants, and

WHEREAS, much effort and hard work has been expended by the members of the Forsyth County Pharmaceutical Society and local auxiliary members to ensure the success of this meeting,

THEREFORE BE IT RESOLVED THAT, sincere appreciation be extended to the program participants and local committee members, and

BE IT FURTHER RESOLVED THAT, special recognition and thanks be expressed to Mr. and Mrs. A. C. Dollar, Convention Co-Chairman, for the many hours they have put into this convention planning, and

BE IT FURTHER RESOLVED THAT, recognition be accorded to the Wholesale Druggists of North Carolina, The Traveling Members Auxiliary, The Woman's Auxiliary, convention sponsors and other contributors who helped make this 102nd Convention one of the most productive and informative in recent memory.

ADOPTED 4/6/82

Resolution No. 2
Short Title: STANDARDS FOR PATIENT PROFILES
From the Committee on Public Health

WHEREAS: Patient Medication Profiles are an important component in the delivery of quality pharmaceutical service, and

WHEREAS, no standards have been developed for patient medication record systems,

BE IT RESOLVED THAT, the NCPhA work with other pharmacy organizations to develop a set of minimum standards for patient medication profile systems to ensure maximum patient benefit.

ADOPTED 4/6/82

Resolution No. 3
Short Title: PD—DOCTOR OF PHARMACY DESIGNATION
From the PD ad hoc Study Committee

WHEREAS, the 1981 North Carolina Pharmaceutical Association Convention, held in Charlotte, North Carolina, called for a committee of the North Carolina Pharmaceutical Association to study the "PD" designation and title "Doctor of Pharmacy," and

WHEREAS, this committee was charged by that Convention to make a report to the North Carolina Pharmaceutical Association no later than at the 1982 Convention to be held in Winston-Salem, North Carolina, and

WHEREAS, this committee was properly formed (PD ad hoc Study Committee) and met to study the "PD" designation and title "Doctor of Pharmacy," and

WHEREAS, the PD ad hoc Study Committee unanimously decided to recommend to the 1982 North Carolina Pharmaceutical As-

sociation Convention that they endorse the "PD" designation and title "Doctor of Pharmacy," and

WHEREAS, the PD ad hoc Study Committee unanimously decided to recommend to the 1982 North Carolina Pharmaceutical Association Convention that the North Carolina Pharmaceutical Association actively pursue Continuing Education for Doctors of Pharmacy, therefore

BE IT RESOLVED, that the North Carolina Pharmaceutical Association shall endorse the designation "PD" for all North Carolina pharmacists, and

BE IT FURTHER RESOLVED, that the North Carolina Pharmaceutical Association, shall endorse the title "Doctor of Pharmacy" for all North Carolina pharmacists, and

BE IT FURTHER RESOLVED, that the North Carolina Pharmaceutical Association shall actively pursue continuing education for Doctors of Pharmacy.

ADOPTED 4/6/82

Resolution No. 4
Short Title: C. E. PROGRAMS AT CONVENTIONS
From the Committee on Women in Pharmacy

WHEREAS: Continuing education programs appeal to a great number of pharmacists,

BE IT RESOLVED THAT the North Carolina Pharmaceutical Association continue to increase the number of continuing education programs offered at the annual convention. These programs are of much interest to pharmacists from various pharmaceutical careers and the programs would serve to draw more individuals to the annual convention.

ADOPTED 4/6/82

Resolution No. 5
Short Title: SELF-IMAGE/LIFESTYLE OF PHARMACY STUDENTS
From the Committee on Public and Professional Relations

WHEREAS: The Committee on Public and Professional Relations is cognizant of the many and valuable contributions that can be made by practitioners to the educational and professionalization process of pharmacy students,

THEREFORE BE IT RESOLVED THAT the North Carolina Pharmaceutical Association, with the University of North Carolina School of Pharmacy, explore ways and means whereby positive self-image and lifestyle habits can be developed and promoted for the pharmacy student and pharmacist.

ADOPTED 4/6/82

Resolution No. 6
Short Title: SCHEDULE II ANOREXIANTS
From the Committee on Public Health

WHEREAS: Schedule II anorexiants are of limited effectiveness, have high potential for abuse, and are popular street drugs, and

WHEREAS, pharmacies stocking such products are susceptible to employee theft, burglary or armed robbery,

THEREFORE IT BE RESOLVED THAT Schedule II controlled substances be banned for use as anorexiants in North Carolina, and

BE IT FURTHER RESOLVED THAT copies of this resolution be sent to the North Carolina Medical Society.

DEFEATED

Resolution No. 7
Short Title: COMMITTEE SIGN-UP SHEET
From the Committee on Women in Pharmacy

WHEREAS: Members of NCPhA may have resources to offer the NCPhA not reflected in the current committee sign-up sheet mailed annually to members, and

WHEREAS increased participation is vital to members as individuals and to the profession,

BE IT RESOLVED THAT THE NCPhA recommends that the "committee sign-up sheet", be expanded to gather other information which would reflex other resources

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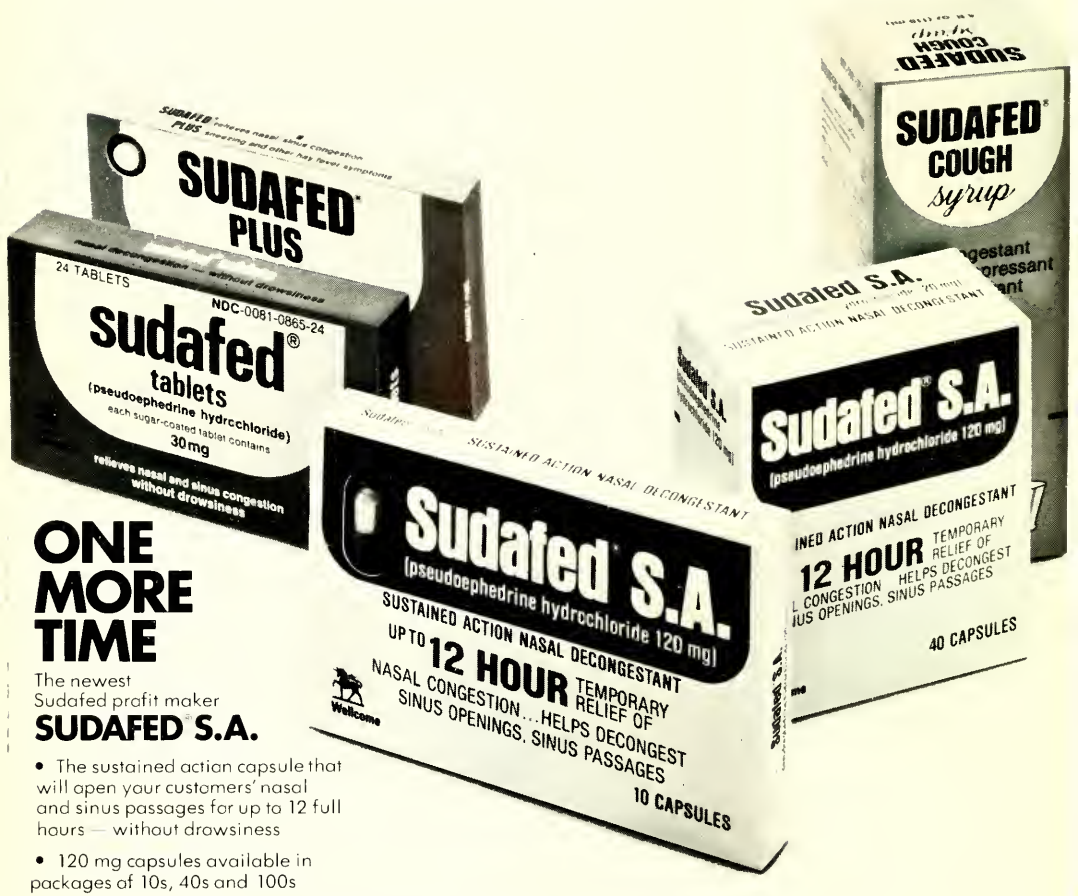

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References: 1. Open Call Survey, *Am Druggist*, Sept 1981 2. Data on file, Burroughs Wellcome Co

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a member may have to offer the Association. Such as:
—Do you wish to run for an office? If so, which office?
—Would you like to chair a committee? If so, which committee?
—What skills or experiences do you possess which would be an asset to an office or position you would like to hold?

ADOPTED 4/6/82

Resolution No. 8
Short Title: OUTPATIENT DISPENSING

WHEREAS, Certain not for profit facilities dispense prescriptions to outpatients, and

WHEREAS, some of these facilities use our tax dollars to compete with our members for prescription business, and

WHEREAS, the courts have ruled in the Portland decision that separate drug stocks must be maintained for outpatient dispensing;

THEREFORE BE IT RESOLVED THAT the North Carolina Pharmaceutical Association recommend to the North Carolina Hospital Association and to the North Carolina Society of Hospital Pharmacists that where these inequities exist, contract or bid price drugs shall not be dispensed to outpatients.

ADOPTED 4/6/82

Resolution No. 9
Short Title: NDA—ANDA
From the Committee on National Legislation

WHEREAS, in the interest of public health, the pharmacist's concern about the adequacy of evidence submitted in support of an Abbreviated New Drug Application (ANDA) (including a paper New Drug Application (NDA)) is fully justified, and

WHEREAS, there is concern about the adequacy of the evidence based primarily on publication growing out of experience with another manufacturer's product,

RESOLVED BY THE NORTH CAROLINA PHARMACEUTICAL ASSOCIATION, that a drug product introduced by a manufacturer under an ANDA (including a paper NDA) must, for approval, be supported by a minimum of actual clinical evidence that the specific manufacturer's product performs therapeutically in a manner equivalent to the approved drug product upon which the published evidence cited is based.

BE IT FURTHER RESOLVED THAT, the North Carolina Pharmaceutical Association transmit this resolution to the Food and Drug Administration and any other parties that might bring about this change.

ADOPTED 4/6/82

Resolution No. 10
Short Title: ABOLISHMENT OF INSTITUTIONAL PHARMACY COMMITTEE
From the Committee on Institutional Pharmacy

WHEREAS: The NCPhA Committee on Institutional Pharmacy is not effectively meeting the needs of pharmacists practicing in institutions such as hospitals or extended care facilities, and

WHEREAS, the NC Society of Hospital Pharmacists is more effectively meeting the needs of hospital pharmacists, and

WHEREAS, the NC Academy of Consulting Pharmacy more effectively represents the needs of long term care pharmacy providers, and

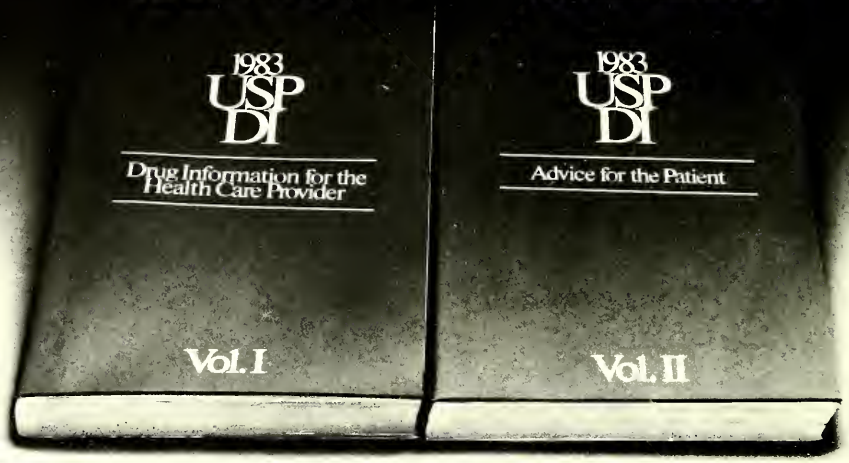
WHEREAS, even though separate needs exist among these three organizations, common goals unite them as professionals,

THEREFORE BE IT RESOLVED THAT the NCPhA Committee on Institutional Pharmacy be disbanded, and

BE IT FURTHER RESOLVED THAT representatives of the NCPhA, NCSHP and NCACP meet to formulate recommendations to better meet the needs of institutional and extended care pharmacy. These recommendations are to be submitted at the 1983 Annual Convention of the NCPhA in Boone.

ADOPTED 4/6/82

SEPARATE BUT EQUALLY INDISPENSABLE.



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Resolution No. 11
Short Title: Dues increase

WHEREAS, there is evidence that the North Carolina Pharmaceutical Association has need for more influence in the political arenas of the State of North Carolina, and the Profession of Pharmacy is more and more affected by decisions made by the General Assembly of the State of North Carolina, and

WHEREAS, in addition to the importance of the Community Pharmacist wielding an influence with his local representatives, it is equally important that a careful watch be kept at the State Capitol upon legislation and regulation, and

WHEREAS, the North Carolina Pharmaceutical Association and The North Carolina Society of Hospital Pharmacists have entered into an agreement toward this objective, and sufficient funds must be secured by both organizations.

THEREFORE BE IT RESOLVED THAT; the Constitution and By-Laws of the North Carolina Pharmaceutical Association, Article IV, Subsection (a) be amended to allow an increase in annual dues up to, but no more than $15.00, the proceeds to be available for the expenses of lobbying and influencing the General Assembly of the State of North Carolina.

ADOPTED AS AMENDED

Resolution No. 12
Short TITLE: MANAGEMENT C. E.
From the Committee on Women in Pharmacy

WHEREAS: In a study performed by Marvin Shepherd and Kenneth Kirk for the APhA Task Force on Women in Pharmacy, it was found that career commitment in terms of desiring a managerial position was just as strong among women as among men with about half of each wishing to be some type of manager/supervisor.

BE IT RESOLVED THAT NCPhA recommends that the North Carolina Pharmaceutical Association, through its continuing education programs, offer the membership continuing education related to the development of management skills. Such as employee motivation, applicant evaluation, resume preparation, employee termination, effective interviewing of applicants, job interviewing and any other management skills.

ADOPTED 4/6/82

Resolution No. 13
Short Title: QUALITY OF HEALTH CARE/ MEDICARE & MEDICAID
From the National Legislation Committee

WHEREAS, the citizens of North Carolina deserve to have the best medical care available at reasonable cost and accessibility;

WHEREAS, President Reagan's budget cuts affecting the quality and services of Medicaid and Medicare could have dramatic effects on the delivery of quality health care products and services in North Carolina.

WHEREAS, the North Carolina Pharmaceutical Association's primary interest is in the delivery of quality health care services and products; and

WHEREAS, the North Carolina Medical Society's interest is in delivering quality health care services to North Carolina citizens,

BE IT RESOLVED THAT the North Carolina Pharmaceutical Association should immediately approach the Medical Society of North Carolina to assure that the members of both organizations continue to provide quality health care services and medical care, to Medicare and Medicaid recipients.

TABLED. *Referred back to Committee*

Resolution No. 14
Short Title: SAMPLING OF CONTROLLED SUBSTANCES
From the Committee on Public Health

WHEREAS: Sampling of controlled substances is not necessary for the successful promotion of these drug products, and

WHEREAS, manufacturers representatives are subject to robbery and other acts of violence because they carry such samples, and

WHEREAS, through office and home burglaries of such samples increase diversion of the controlled substances,

THEREFORE BE IT RESOLVED, the NCPhA through legislative and regulatory means seek to have the sampling of controlled substances banned in North Carolina.

ADOPTED 4/6/82

Resolution No. 15
Short Title: POSTMARKETING SURVEILLANCE
From the Committee on National Legislation

WHEREAS: Postmarketing surveillance (PMS) of certain drugs and drug products can and should be a major factor in their clinical use with appropriate assurance of efficacy and safety and,

WHEREAS, PMS can and should expedite the approval process through which an innovative drug and drug product are made available for clinical application, and,

WHEREAS, the pharmacist's participation is essential for PMS activities for the welfare of the public and, at the same time, promotes the pharmacist's clinical role and enhances perception of the pharmacist's importance in safe and effective pharmacotherapy,

BE IT RESOLVED THAT, the North Carolina Pharmaceutical Association and its members affirm their earnest desire to participate in PMS activities with greater diligence and reliability and,

BE IT FURTHER RESOLVED THAT, the North Carolina Pharmaceutical Association undertake immediately the intraprofessional and interprofessional activities that are appropriate for the participation of North Carolina pharmacists in a first rate PMS system.

ADOPTED 4/6/82

Resolution No. 16
Short Title: PREPRINTED BLANKS FOR CONTROLLED SUBSTANCES

WHEREAS: preprinted prescription blanks for controlled substances increase the potential for forgery and illegal prescriptions and,

WHEREAS, prescribers are not careful about the safekeeping of prescription pads and,

WHEREAS, a blank, preprinted prescription form may be sold on the street for up to $25.00,

BE IT RESOLVED THAT, the North Carolina Pharmaceutical Association work with the North Carolina Medical Society to make the use of preprinted prescription blanks for controlled substances illegal in North Carolina.

ADOPTED 4/6/82

Resolution No. 17
Short Title: MANDATORY C. E.
From the Committee on Continuing Education

WHEREAS, the Pharmacy Practice Act permits the North Carolina Board of Pharmacy to mandate Continuing Education, and

WHEREAS, a need exists among the state's pharmacists to be informed of new developments in Pharmacy and Medicine,

BE IT RESOLVED THAT the North Carolina Pharmaceutical Association endorse implementation of mandatory Continuing Education with the attendant standards of quality and safeguards against undue hardships.

BE IT FURTHER RESOLVED THAT this action proceed as soon as practicable after the passage of the Pharmacy Practice Act into law.

TABLED

Resolution No. 18
Short Title: HIRING PROFESSIONAL LOBBYIST
From N. C. PharmPAC

WHEREAS, the lobby efforts of the NCPhA have been less than adequate in the past several sessions of the N. C. Legislature, and

WHEREAS, the interest of pharmacy in N. C. can better be served by a professional lobbyist who will be in the legislature on a full-time basis while in session, and

WHEREAS, several independent lobbyists have expressed an interest in fulfilling these duties, and

WHEREAS, issues of vital importance to pharmacy are forthcoming in the next few sessions, where distribution of shrinking state revenues could dramatically affect reimbursement for pharmaceutical services and where the N. C. Practice of Pharmacy Act is still waiting to be adopted.

BE IT RESOLVED THAT a portion from the dues paid by each member of the NCPhA be allocated for the purpose of retaining a professional lobbyist and covering the expenses of the Association lobbying effort.

FURTHER BE IT RESOLVED THAT this allocation of funds go into effect on January 1, 1983.

ADOPTED 4/6/82

Resolution No. 19
Short Title: THIRD PARTY LEGISLATION
From Community Practice

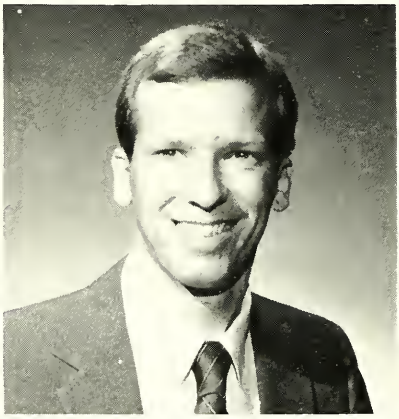
WHEREAS, the Third Party Committee has determined that problems exist in reimbursement by third parties to pharmacies;

THEREFORE BE IT RESOLVED THAT the Executive Committee direct the Legislative Committee to prepare a Bill, including, but not limited to, favorable provisions from other states and those in effect in Georgia, for introduction in the 1983 General Assembly.

ADOPTED 4/6/82

SUMMER INTERNSHIP PROGRAM

David Griffin, a 5th-year student at the University of North Carolina, is accepting a plaque from Douglas P. Johnson, Pharmacy Relations Manager, at The Upjohn Company. David spent 10 weeks this past summer in Kalamazoo, Michigan working for The Upjohn Company as part of the NPC-SAPhA Pharmaceutical Industry Summer Internship Program.



Douglas A. Shoecraft has been assigned to the Lumberton territory for The Upjohn Company. He recently completed four weeks of training at The Upjohn Company Learning Center in Kalamazoo, Michigan. This is part of the ten week initial-phase training for all new Upjohn sales representatives. Doug is a graduate of the University of North Carolina—Charlotte.

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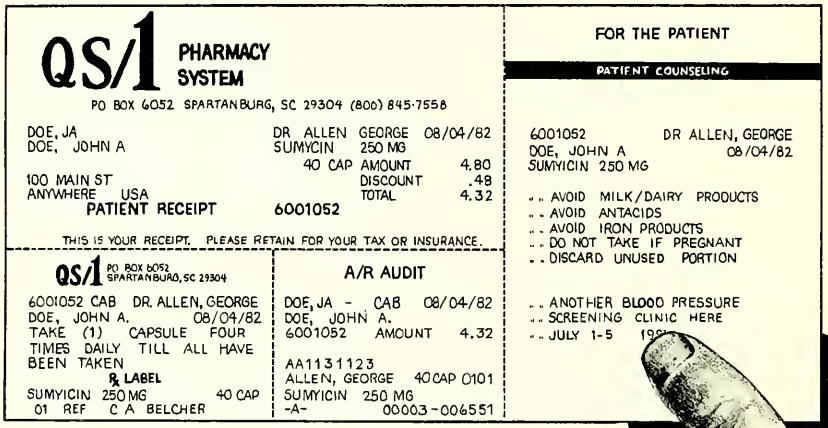

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Thomasville, NC 27360
Joe David Greeson, Ph-Mgr.

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421 Castle Street
Wilmington, NC 28401
William A. Morton, Sr., Ph-Mgr.

Issued 7/1/82 (L.S.P.)
Guilford County Health Dept. Pharmacy
936 Montlieu Avenue
High Point, NC 27262
Myra Joy Wilson Southerland, Ph-Mgr.

Issued 7/1/82
Revco Discount Drug Center
Ashemont S/C, US Hwy. 221
West Jefferson, NC 28694
Jackie Badger Little, Ph-Mgr.

Issued 7/8/82
Asheville Discount Pharmacy, Inc.
57 Haywood Street
Asheville, NC 28801
Haskim Badr, Ph-Mgr.

Issued 6/17/82
Rite Aid Discount Pharmacy
202 E. Washington St., Byrds S/C
Mebane, NC 27302
James Kesler, Ph-Mgr.

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Superx Drugs
2001-2 E. Dixon Blvd.
Shelby, NC 28150
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Family Pharmacy
6428 Old Hwy. 52
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Jackie Flippin, Ph-Mgr.

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Community Pharmacy
NC Rt. #67, Town & Country S/C
Boonville, NC 27011-0277
David L. Ballard, Ph-Mgr.

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The Apothecary
Central Plaza Bldg., 411 Fayetteville St. Mall
Raleigh, NC 27602
Constance S. Upshaw, Ph-Mgr.

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951 Old US #1 South
Southern Pines, NC 28387
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Minton's Pharmacy
Hwy. 19-23
Candler, NC 28715
Thomas M. Allison, Ph-Mgr.

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2474 Hope Mills Rd.
Fayetteville, NC 28304
Darlene Metcalf, Ph-Mgr.

Issued 8/17/82
Rite Aid Discount Pharmacy
Byrds S/C, McClanahan Drive
Oxford, NC 27565
Marquita Ann West, Ph-Mgr.

PHARMACISTS (127) LICENSED TO PRACTICE PHARMACY IN NORTH CAROLINA AS A RESULT OF THE JUNE 1982 EXAMINATIONS CONDUCTED BY THE NORTH CAROLINA BOARD OF PHARMACY

List: Compliments of the North Carolina Pharmaceutical Association

Absher, Randall Kenneth, 1914 Fleming Road, Greensboro, NC 27410
Adams, Jennifer Elaine, 102 Park Avenue, Fuquay-Varina, NC 27526
Alexander, Ginger Quay, 2920 Chapel Hill Rd., 101-D, Durham, NC 27707
Angel, Randall Brent, Rt. 1, Box 324, King, NC 27021
Applewhite, Ritchie Murdock, Rt. 1, Box 95, Snow Hill, NC 28580
Auld, Martha Anne, Route 1, Box 133-A, Morrisville, NC 27560
Ball, Jan Elizabeth, 500 Umstead Dr., Apt. 304-F, Chapel Hill, NC 27514
Barnes, Betsy Ruth, 2920 Chapel Hill Rd., Apt. 101-D, Durham, NC 27707
Barringer, Mahlon Dwight, Jr., 3140 Iris Street, Winston-Salem, NC 27107
Bass, Joe Jackson, Jr., Route 1, Box 301, Faison, NC 28341
Beck, Pamela Kay, Route 1, Box 445, Mooresville, NC 28115
Bennett, Martha West, P. O. Box 213, Farmville, NC 27828
Blackman, Lorena Paige, 3207 Pine Needles Rd., High Point, NC 27260
Boyd, Alan Fenner, 5126 Lazy Wood Lane, Durham, NC 27712
Brewer, Brian Keith, Rt. 5, Box 82-A, Hooper Dr., Laurinburg, NC 28352
Brown, Hunter Creech, 146 Cove Dr.-Ctry Club Cove Apt, Rocky Mount, NC 27801
Brown, Mary Ella, 4622-N Colony Road, Charlotte, NC 28211
Bruestle, Terri Lynn, 818 2nd St. Place, NE #79, Hickory, NC 28601
Burroughs, Terrence VanLoren, 5405 Edington Lane, Raleigh, NC 27604
Calverley, Carolyn Sue, 3029 Lewis Farm Rd., Raleigh, NC 27607
Carringer, Laura Banner, 303-A Mason Farm Road, Chapel Hill, NC 27514
Carroll, Mary Puckett, 208 McDonald Ave., Hamlet, NC 28345
Cauley, Elizabeth Renee, 603 S. Fayetteville St., Clayton, NC 27520
Caviness, James Keith, Route 2, Box 124-B, Bennett, NC 27208
Chitty, Catherine Jane, 1312 Green Springs Road, New Bern, NC 28560
Chu, Paul, Apt. 14-J Briarwood Arms, Fayetteville, NC 28306
Clelland, Susan Lazelle, 596 Murray Hill Rd., Fayetteville, NC 28303
Clevenger, Robert Brent, III, P. O. Box 243, Washington, NC 27889
Cline, Ralph Dalton, Jr., 311 S. LaSalle, Apt. 11-H, Durham, NC 27705
Cobb, Jerrel Wood, Jr., 1311 Sycamore Dr., Garner, NC 27529
Coppedge, William Walter, 405 Dock Street, Wilmington, NC 28401
Corbett, Jean Hesse, 1313 Quail Court, Roanoke Rapids, NC 27870
Creel, Richard Nash, 408 S. Ellis St., Salisbury, NC 28144
Crew, Carroll Anna, 2115 Weybridge Drive, Raleigh, NC 27609
Davis, Gary Mark, Route 2, Box 526, Lexington, NC 27292
Davis, Linda Mercer, 5048-C Edwards Mill Road, Raleigh, NC 27612
Decker, Susan Rhea, 207 Country Park Rd., Greensboro, NC 27408
Dove, George DeLon, P. O. Box 1532, Atlantic Beach, NC 28512
Downing, Michael Eugene, 4831 Carolina Beach Road, Wilmington, NC 28403
Dozier, William Gregory, Route 2, Box WA-48, Williamston, NC 27892
Earnhardt, Charles Edward, IV, 4906 Tiffany Ave., Winston-Salem, NC 27104
Epps, Kenneth Roger, 5234 Hornbeam Rd., Fayetteville, NC 28304
Faught, Megan Leigh, I-7 The Villages, Carrboro, NC 27510

Feudale, Page Hardison, 351 Hocutt Road, Durham, NC 27703
Flowers, Betty Melissa, 200-C West Park Ave., Tarboro, NC 27886
Foster, David Scott, 5674 Chancellorsville Dr., Winston-Salem, NC 27106
Fowler, Janet Leigh, 3740-E Moss Drive, Winston-Salem, NC 27106
Furr, Stephen Richards, 110 S. Summit, Greenville, NC 27834
Galloway, Joseph Richmond, Jr., Rt. 3, Box 256-A, Supply, NC 28462
Galloway, Susan Heath, Wedgewood Arms, 423 Greenville, NC 27834
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Hall, Tammy Coble, 703-A Trail Two, Burlington, NC 27215
Hardy, Hugh Dan, Jr., 24 Carriage House Apts., Greenville, NC 27834
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Hill, Cynthia Hartman, 410 Chateau Apts., Carrboro, NC 27510
Hinson, John Lee, Jr., Route 14, Box 427, Goldsboro, NC 27530
Hollowell, Linda Ann, 2132 Bedford St., Apt. 12, Durham, NC 27707
Howell, Admiral Griffith, Jr., 200-D Branson Street, Chapel Hill, NC 27514
Howell, Charlotta King, 216 S. Bethel Rd., Raeford, NC 28376
Huff, Jamie Blythe, Rt. 7, Box 99, Oxford, NC 27565
Johnson, Alton Dale, Route 3, Box 85, Denton, NC 27239
Johnson, Karen Elizabeth, 702 N Farmhurst Drive, Charlotte, NC 28210
Johnson, Susan Halliday, 64 Tacoma Circle, Asheville, NC 28801
Kendrick, Cheryl Denise, 4203 Lake Jeanette Rd., Greensboro, NC 27408
King, Gordon McDonald, 925 Long Drive, Winston-Salem, NC 27106
Kirby, Marvin Gray, Jr., 3170 Spainhour Mill Road, Tobaccoville, NC 27050
Lapierre, Ginette, 204 Oak Street, Apt. 3, Greenville, NC 27834
Lassiter, Timothy Francis, 11-K Estes Park Apts., Carrboro, NC 27510
Ledbetter, Barry Christopher, 819 Cedar Point Cr., Elizabeth City, NC 27909
Lee, Donna Sue, Randolph Mem. Hosp., Pharm Dept., Asheboro, NC 27203
Lee, William Homer, Jr., Route 4, Box 124, Benson, NC 27504
Leeuwenburg, Katrina Sue, 130 Martingale Lane, Wilmington, NC 28403
Lindsay, Debra Lee, 227 McCauley Street, Chapel Hill, NC 27514
Lingenfelser, Susan Lee, 2521 Amesbury Rd., Winston-Salem, NC 27103
Locklear, Eric Paul, P. O. Box 445, Pembroke, NC 28372
MacDonald, John Ewald, 1631 B Gretel Lane, Winston-Salem, NC 27107
Mallory, Erma Jean, 202 Pettigrew Dr., Plymouth, NC 27962
Malpass, George Lloyd, Route 1, Box 433, Dudley, NC 28333
Masterson, Norman Page, Rt. 2, Box 43-B, Forest City, NC 28043
McCosley, Daniel Allen, Route 2, Box 218, New Bern, NC 28560
McKnight, David Lanier, P. O. Box 185, Taylor Street, Buies Creek, NC 27506
McNeill, Martha Faye, P. O. Box 188, St. Pauls, NC 28384
McSwain, David Smith, 2412-A Chartres Drive, Gastonia, NC 28052
Meade, Glen Earl, Jr., 410-B Rhodes Ave., Kinston, NC 28501
Messer, Deborah Presson, 2030 Fleetwood Drive, Gastonia, NC 28052
Meyer, David P., 1103 Olive Street, Apt. D, Greensboro, NC 27401
Miller, Edward Alan, Route 3, Box 456, Statesville, NC 28677
Mis, Lydia, 901 Chalk Level Rd., Apt. A-13, Durham, NC 27704
Mitchum, Tony Lee, 204 Finley Road, Chapel Hill, NC 27514
Muse, Martha Carol, 6117 Heath Ridge Ct., Charlotte, NC 28210

(continued on page 16)

NEWLY LICENSED PHARMACISTS

Naylor, Olen Cyde, Jr., 56 Greeneway Apt., Greenville, NC 27834
Owens, David Van, 1114 Longleaf Drive, Fayetteville, NC 28305
Parker, Eric McFee, 6 Knoll Ridge Road, Candler, NC 28715
Parker, Ronald McKinnon, Rt. 2, Box J-130, Hamlet, NC 28345
Parks, Katherine Ann, 317 Armory Road, Galax, VA 24333
Parris, Anne Brookshire, P. O. Box 213, Candler, NC 28715
Perkins, James Finley, 108 Park Avenue, Brevard, NC 28712
Richard, Brian Edwin, Route 3, Box 457, Maiden, NC 28650
Riddick, Kenneth Barts, Route 1, Aulander, NC 27805
Rogers, Melany Ann, 303-1 Pinegate Circle, Chapel Hill, NC 27514
Rowe, Toni Lynn, 500-D Ridge Townhouse Apt., Asheville, NC 28805
Saunders, Joseph Allan, Jr., 213 DeVane St., Fayetteville, NC 28305
Scudder, Samuel Alan, Rt. 4, Box 415-A, Zebulon, NC 27597
Silta, William Henry, Jr., Rt. 4, Box 417-F, Chapel Hill, NC 27514
Sitterson, Susanne Byrd, Box 672, Denver, NC 28037
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Strickland, Jenny Lynn, Rt. 1, Box 145, Clinton, NC 28328
Taylor, Linda Helton, 914-B Lakecrest Ave., High Point, NC 27260
Thrasher, Kimberly Anne, Rt. 4, Box 81, Mooresville, NC 28115
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Vinson, Joseph Stephen, 112 W. Franklin Street, Zebulon, NC 27597
Wagoner, Lynne Elizabeth, Route 1, Box 55-B, Gibsonville, NC 27249
Warren, Diane Kay, 631 Fagg Dr., Apt. 11-B, Eden, NC 27288
Weaver, Royal Worth, III, 102-B Bernard St., Chapel Hill, NC 27514
Welborn, Sandra Marie, 914 H St. (Upstairs Apt.), N. Wilkesboro, NC 28659
Welch, Ronald Martin, 8808 Katharina Court, Raleigh, NC 27612
White, Dana Ann, Route 1, Box 405, Cleveland, NC 27013
White, Paul McIntyre, 10-F Barbcrest Apts.,Whiteville, NC 28472
White, Romas Templeton, III, 3613 Old Post Road, Raleigh, NC 27612
Winship, Linda Carol, 622 Elgin Terrace, Richmond, VA 23225
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CORNWELL DRUG STORES CELEBRATE 50 YEARS

Cornwell Drugs Stores, Inc. celebrated its half a century of operation at a 50th anniversary and employee appreciation banquet at the Community House in Morganton, Wednesday, April 21. More than 175 employees from all 15 stores attended the event. Ronnie Austell, vice president, served as master of ceremonies. The main feature of the evening was a surprise tribute honoring G. T. (Tom) Cornwell, who founded the company in 1932, and his brother Hal Cornwell, who joined him in 1937. Jerry T. Norvell, president, gave the welcome and read a history of the company.

Mr. Norvell:

"Fifty years ago this September, Cornwell Drug Co.'s first store was opened in Shelby. "Sloope Pharmacy" was bought in a bankruptcy sale for $2,120.00. That was the bid and all of the money was borrowed—we had no working capital, no credit, no customers and no experience to fall back on. One can't realize what it was like trying to start a business then—old fixtures, old fountain, out-dated merchandise and all on borrowed money.

Franklin D. Roosevelt was inaugurated as president March 4, 1933 and declared a banking holiday for all banks. Some reopened in 10 days and many never reopened. Some of the banks allowed their depositors to draw their money out over a period of months—a % of what they had on deposit when the holiday was declared and had checks out for more than that and some of our creditors really made it uncomfortable for us! Businesses that had been operating for many years were declaring bankruptcy! People were panicky, despondent, and just plain scared! Those who had money wouldn't spend it because they didn't know what was going to happen.

Store hours were long then. We opened at 6:00 a.m. and closed at 10:00 p.m., 5 days a week. On Saturdays, we opened at 6:00 a.m. and closed at 11:00 or 12:00 p.m., depending on whether we had any customers. This is, as you can see, about a 90 hour week but there was no thought about the long hours because it was a matter of survival! No one would recommend these hours today, but when one learns during periods of adversity the lessons never leave.

There were 4 people on our payroll in 1932:

Bob Austin who was paid $120.00 per month.

G. T. Cornwell who was paid $60.00 per month.

Frank Abernathy, (part-time) who was paid $30.00 per month.

Joseph, (part-time) who was paid $16.00 per month.

Gross sales the first 12 months were $15,460.29. Sales for the month of September 1932 were $1,090.00. In spite of these depressing times, it is interesting to note that we paid interest on what we owed (3%) and paid $300.00 on our note at the end of our 12 month period. Many things happened to help us forget the "toil, sweat and tears." There were many wonderful people then as well as now. The people who owned the building we rented from told us to forget the rent until such time as we could pay. Most of our creditors were very lenient with us, and we should always be grateful for the courtesies we received from Kendall Medicine Co. If it had not been for Kendall Medicine Co. things would have been much more unpleasant for us.

In the summer of 1933, our business began to pick up and has shown steady progress every year since. We paid our note off in 3 years. Even when World War II came along when Hal, Clayton, Ed, and others were all drafted we still made progress in sales and profits.

In 1936 we bought our first store in Morganton, the Davis Drug Co., and in 1937 Hal Cornwell, who had just received his pharmacy license, began working and also in 1937 Clayton Braswell and Ed Wakefield joined the company. These 3 spent their entire business life with Cornwell Drug Co. Hal and Clayton have retired but Ed Wakefield is still very active in the Morganton Store.

Hal Cornwell opened the Economy Drug Co. in Lincolnton, N. C. in 1939. Drexel Drug Co. was opened in the middle 40's. Cornwell Drug Co. #4 in Medical Center in Shelby was opened in the early 1950's.

Cornwell Drug Co. was operated as a partnership during this time, but in 1953 it was incorporated as Cornwell Drug Stores, Inc. Operating at that time stores in Shelby, Morganton,

(continued next page)

CORNWELL

Lincolnton, Drexel, and Stanley. Stock was offered to registered pharmacists Clayton Braswell and Ed Wakefield. Newton Drug Co. was opened in the middle '50's. Since then more stores have been opened in Shelby, Morganton, Lincolnton, Maiden, Marion, Dallas, and Kings Mountain. Our two latest stores have been opened in Davidson and Stanley. These two stores are our largest stores with 6,000 square feet.

It might be of some interest to note that during these 50 years, Cornwell Drug Stores, Inc. has sold one (1) store and merged four (4) and are now operating 14 drug stores and a gift shop. Sales have continued to grow each year. The year 1981, sales *increased* $600,000.00 over the prior year! This sounds astronomical compared with sales in 1932!

In September of 1978, the principal stockholders of Cornwell Drug Stores, Inc. entered into an agreement to sell their stock to their employees through an employee stock ownership plan known as "ESOP" and that continues to be the structure in which we operate.

There were four speakers who paid tribute to the two Cornwell brothers, reminisced and related humerous experiences about them; Rush Hamrick, Shelby, president of Kendall Drug Co., Paul Walker, Newton, executive vice president and general manager, Cornwell Drugs, Jimmy Bowers, Lincolnton, Cornwell vice president, and W. J. Smith, retired executive director, North Carolina Pharmaceutical Association and classmate of Hal Cornwell and the University of North Carolina.

Mr. Smith:

It is a privilege to join with others in paying tribute to Tom and Hal Cornwell and the Cornwell Pharmacy organization on this special occasion. Since I have been acquainted with Tom and Hal for forty years and with some of the Cornwell Pharmacy managers for a lesser period, and am aware of their significant contributions to the progress of North Carolina Pharmacy, I welcome this opportunity to be a part of this well-deserved party in their honor tonight.

Due to the program time factor, I asked Jerry about the length of my comments. He responded by quoting Chapter 32, Verse 28, of Proverbs: "He who thinketh by the inch but speaketh by the yard should be kickith by the foot." Although there is no Chapter 32 of Proverbs, I got the message—keep it short.

Some of you are aware I am a native of Mortanton. Sam J. Ervin, Jr., later Senator Ervin, was our high school commencement speaker in 1930. I do not recall any of his words of wisdom passed along to the 1930 Morganton High School graduates but I am fairly confident he did not advise us to avoid the pitfalls of Watergate.

I became acquainted with Hal Cornwell while we were pharmacy students at the University of North Carolina in the mid-thirties. Two things stand out in my memory of Hal: (1) His infectious laughter which at times brought classwork to a standstill, and (2) his participation in the English 51 class, which, among other things, was supposed to enhance our knowledge of business letter writing and public speaking. A requirement was each member of the class deliver a five minute speech on a topic of his or her choice. Hal decided to enlighten his classmates on the curative value of Kendall's salvation oil, and, as the book suggested, he walked to the front of the classroom, assumed a military stance, and eye-balled his classmates. What Hal did not anticipate, and this caused some nervous tension on his part, his classmates eye-balled him right back. At this point, Hal's position could best be described as immobilized, or some what like the confederate soldier who is mounted on a granite base on the campus of the University of North Carolina, named appropriately by the students as "Silent Sam."

Hal brought the classroom tension to an end by saying: "I am so emotionally overcome with the merits of Kendall's salvation oil, I can't say a word." The class response was so positive; in fact, the applause so loud and sustained, it was not matched until Carolina scored its final 2-pointer against Georgetown to win the 1982 national basketball championship. At this point, the class instructor walked up to Hal and said: "Mr. Cornwell, I want you to know in advance I am posting an A plus grade on your response to what could have been a nerve-shattering experience.

(continued next page)

CORNWELL

Hal is a very modest fellow. He will probably indicate none of this took place and after forty years, the details do get a bit hazy. But the record is there—Hal did graduate from the University of North Carolina.

Nothing changes like change itself. As an example, contrast admission policies at UNC during the period when Hal was enrolled with those prevailing today. More than 90% of Dean Smith's basketball players have graduated and gone on to successful business and professional careers. In the mid-30's, Hal may or may not have been acquainted with a football player, who, up for admission to UNC, was informed he would be admitted provided he would correctly answer one question: what is the capitol of North Carolina? The football player's answer was "Apex." The admission officer, not wanting to lose a prime prospect, said "since Apex is twelve miles from Raleigh, the state's capitol, you get a passing grade of 88."

While all this was taking place in Chapel Hill, Tom Cornwell was applying his business knowledge and pharmaceutical skill in Morganton as he got the Cornwell flagship underway. In my then position as inspector for the North Carolina Board of Pharmacy, I was present in Tom's prescription laboratory one day when I witnessed him compound a liquid prescription. First, he placed a carefully weighed quantity of brown powder in a glass mortar, then dissolved the powder in an acid liquid. Ike Emerson of bromo-seltzer fame would have been proud of the effervescent action which next followed when Tom added an alkaline base to the acidified liquid. Large brown bubbles filled the mortar and started to edge over the sides. Tom poured half the liquid into a 500 cc beaker, and when the breaker filled, he poured half its contents into a large wedgewood mortar. At this point, the chemical reaction ceased. While I did not express myself at the time, on reflection, I considered it best that the chemical action took place in Tom Cornwell's prescription laboratory rather than the patient's stomach.

In my inspection report to the state board of pharmacy, I wrote: "Tom Cornwell practices pharmacy secumdum artem. Those of you who remember your pharmaceutical latin know that I had something complimentary to say about Tom Cornwell, although he did not win the Nobel Prize for chemistry that year.

The 1950s and the 1960s stand out in my memory of the Cornwells and the Cornwell Pharmacy organization because it was during that era the consolidated pharmacy student loan fund was founded and the Cornwell building at Mars Hill College dedicated.

Support of the Consolidated Pharmacy student loan fund at UNC—it dates back to 1954—has been consistent by the Cornwell pharmacy organization. As a director of the fund, Tom Cornwell has been most generous in time and money to help assure the success of the operation. The fund, which has been instrumental in providing much needed assistance to hundreds of pharmacy students in the past twenty-five years, is now the largest fund of its type administered by a state pharmaceutical association in the United States. As an executive officer associated with the fund for many years, I can assure you your support has not been misplaced.

I was fortunate to receive an invitation to attend the ceremony dedicating the Cornwell building at Mars Hill College. It is an impressive building just as is the pharmacist who made the building possible. The bronze plaque at the building's entrance, which bears Tom's profile, will be around a long time to remind future students at Mars Hill College there are folks out there who care.

At the time the building was dedicated, a friend of mine from Washington, North Carolina, a Mars Hill student of the 1920s, received an invitation to attend the dedication ceremony. Since he could not attend, he asked me to represent him at the ceremony. While this did not take place, I could not refrain from passing this message along to my friend who inquired about the day's events. "I mentioned your name to officials of the college but they could not remember you. But they did state that if you would send $100,000 to the college, it would help to jog their memory."

Tom Cornwell has an admirable trait of making those who seek his advice and counsel to feel at ease. He is not subject to erratic behavior; is even-tempered under the most trying circumstances. The only evidence we have to the contrary is that one time, when a wrong-thinker made a disparaging remark about Mars Hill College, it was reported Tom left in a huff. When

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CORNWELL

Tom Cornwell goes, he goes in style. He left in a huff. I doubt very seriously if brother Hal has ever ridden in a huff.

During the 40s, 50s, and 60s, I saw a great deal of Hal Cornwell who was in and out of Chapel Hill in connection with drug store permit applications and seeking pharmacist personnel for the growing Cornwell Pharmacy organization. Those of you who were employed by Hal during the period just cited and who continue with the organization today, cannot but be imbued with a sense of pride by being one of those selected since Hal's standards were high. He was only interested in the pharmacy graduate who possessed a high degree of motivation to succeed, a go-getter, not a clock-watcher; and one with a special ability to get along with people at all levels.

Hal Cornwell would have made a good recruiter for our football or basketball teams for a good measure of the success of the Cornwell pharmacy organization can be attributed to his personnel recruitment policies.

In reviewing Hal's career folder, which covers a forty year period, it is outstanding in the scope of public and professional service, marred only by one minor flaw which, on balance, is of little consequence. In 1954, Hal sold a box of 4 way cold tablets to a customer who later complained the 4 way cold tablets worked only one way. Tablets or pills, all you employees and officers in attendance at this employees appreciation banquet can take pride in the fact you are associated with a profession that is so closely allied to God, the great physician, who said to Moses, "Moses, take these tablets."

To you wives, a special note of commendation because you made it all possible. How many times did you watch a well-prepared dinner go cold while your husband was back in the pharmacy busy with a last minute prescription; a prescription which, in some instances, spelled life or death for an ill person? On reflection, you would not have wanted it otherwise. In my case, hundreds of resolutions, citations and proclamations which carried my imprint were written by my wife, Vivian. Yes, the unsung heroes of pharmacy are the wives.

In conclusion, as a tribute to all who have shared in the success of the Cornwell pharmacy organization, as exemplified by this 50th anniversary banquet, I share these final words with you.

I am the faithful slave who answers your calls in the morning, in the evening, at the noontime and at night. I am the world's utility man. My office hours are any hour of any day in the year. My mission is one of service to humanity. My work is a skilled one on which the afflicted must depend, and in which there is no place for a drousy brain or a bungling hand lest they take a human life. I feel the weight of responsibility and note that age is creeping upon me ahead of my years . . . but when I have answered your last call and the long vigil is over, me thinks I shall hear a wee small voice saying: "he helped the world by his service to mankind and this shall be my reward."

The Cornwell brothers were each presented a Carolina blue leather chair, which was embossed with the UNC seal. Both are graduates of the UNC School of Pharmacy. They were joined by their families at this dinner, Hal Cornwell has two daughters and Tom Cornwell has three daughters, all of whom were present.

NORTH CAROLINA SOCIETY OF HOSPITAL PHARMACISTS

Bill Pickard
Clinical Pharmacist
Department of Medicine
Division of Infectious Diseases
Duke University Medical Center
Durham, NC

THE DIAGNOSIS AND TREATMENT OF URINARY TRACT INFECTIONS

A urinary tract infection (UTI) is the most common cause of gram-negative bacteremias which are frequently a life-threatening situation. The outpatient differs somewhat in the method of acquisition of UTI's and the microbiology than the hospitalized patient; nevertheless, the problem is serious and appropriate therapy needs to be instituted.

The clinical diagnosis of a urinary tract infection is made on the presence of significant amounts of bacteria found in the urine or what is termed the "Kass" criteria which is a minimum of 10^5 colonies of bacteria/ml of urine cultured from a properly collected specimen. Invasion of the urinary tract by bacteria is most common via the ascending route. Infections may begin from blood born pathogens (hematogenous route) or through lymphatic channels (renal lymphatics). Confirmation of the suspected infection must be made from a carefully obtained "midstream" or "clean catch" urine specimen. The outer area of the urethra must first be cleansed with a non-antibacterial cleanser to prevent culture contamination. The urine sample to be cultured then should be obtained from the middle of the urine stream. This method of collection, if performed properly, will produce about an 80% reliable result. Although a patient may also exhibit physical symptoms typical of UTI's such as dysuria, urgency, frequency and flank pain, this does not necessarily mean an infection is present.

Females have a higher risk of obtaining UTI's than males. About 25% of all females will have a UTI at sometime in their lives. The incidence is even greater in women of childbearing age on oral contraceptives. The reason for this fact is not known but postulates for it include: (1) increased sexual activity and thus possible increased bacterial contamination, (2) the presence of external hormones which mimic pregnancy and thus dilates ureters and decreases ureteral peristalsis and (3) the vaginal introitus colonization of bacteria which eases bacterial dissemination to the bladder. Post coital bladder emptying by the female to "wash out" bacteria and single doses of antibiotics have shown to be useful in this group of patients. Other factors which may predispose an individual to UTI's are: (1) structural abnormalities, often seen in children, (2) renal stones, (3) foreign bodies such as urinary catheters, (4) infections in men which have localized to the prostate and continually seed the bladder with bacteria, (5) urine pH's favorable to the invading bacteria, (6) high urea concentrations in the urine are favorable to many organisms, (7) the integrity of the host's natural immune system, and (8) the organism innoculum size and virulence.

"Complicated" UTI's are those which may be in need of surgical assistance for correcting existing structural abnormalities or complicated due to the presence of an indwelling urinary catheter. "Uncomplicated" UTI's are those which will need only medical therapy with antibiotics and adjunctive treatment. Once the diagnosis has been made the proper drug must be decided upon. Antibiotic sensitivities for the infecting pathogen must be reviewed once the pathogen is identified. It is important to remember most bacterial sensitivity testing is done in such a manner to compare achievable antibiotic levels in the blood with the ability to kill or inhibit the organism. The one exception to this is nitrofurantoin testing which compares achievable urine levels of the drug to inhibition of bacterial growth. If the infection is confined to the bladder these antibiotic concentrations are most often much larger than serum or blood concentrations due to the mechanism of drug elimination from the body is many times via the renal route. Quite frequently in uncomplicated UTI's the choice of a antibicrobial agent may

URINARY TRACT INFECTIONS

not be critical due to the massive antibiotic concentration achieved in the urine. This is a fortunate pharmacologic fact of life since most therapy is instituted without susceptibility knowledge due to the need of immediate therapy or in community medical office practices where susceptibilities cannot be or are not performed. In any case, the choice of antibiotic needs to be effective, easy for patient compliance, with few side effects and have a low potential for the development of a resistant organism.

The next important decision is the duration of the antibiotic therapy. Most infections clear themselves in the first forty-eight hours of traditional five to fourteen day courses of antibiotics. This fact decreases compliance in patients and the full course of prescribed treatment is not taken. Physicians are using single dose therapy on a more frequent basis. Numerous controlled studies have shown single, usually large dose therapy to be as effective as the older accepted standards of five to fourteen days. Other advantages of single dose treatment are the simplicity of therapy, improved compliance, inexpensive drug cost and few side effects. Failure of single dose courses of antibiotics or more complicated infections are indications for more conventional therapy durations with the appropriate antimicrobial agent. For effective treatment of complicated infections it is paramount that the obstruction or presence of the foreign body (whether it be renal stone or urinary catheter) be dealt with, surgically if necessary, for proper clearance of the infectious problem. Recurrence is a problem often associated with the presence of a resistant organism. It is useful to perform follow-up urine cultures to prove sterilization of the urine after the antibiotic course is completed to formulate decisions on the need for long term suppressive or prophylactic antibiotic treatment. The need for long term prophylaxis may be apparent at the completion of what one might consider a full or normal length of therapy. Small doses of antibiotics are administered for months at a time for the purpose of prophylaxis or suppression. It is better to administer the antibiotics at bedtime due to decreased bladder emptying for a long period of time which will increase the concentration of the antimicrobial agent chosen. The organism antibiotic susceptibility results must be known

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URINARY TRACT INFECTIONS

in the long term prophylactic setting to avoid the waste of patient time, efforts and money by treating a resistant organism.

Recurrence of initial infections is a frequent problem. In males, prostatitis may be present which provides a constant flow of bacteria in the bladder. This is a difficult problem in that few antibiotics penetrate the prostate well. Drugs such as trimethoprim, doxycycline and minocycline usually achieve adequate prostatic fluid concentrations which make them useful in this case. In females, bladder emptying after intercourse and administration of a post-intercourse antimicrobial agent may be helpful. It is generally considered today that there is no indication in this group of females for long term prophylactic therapy but each recurrence should be treated with a full, traditional length antibiotic course. One of the major problems of recurrence is a physicological one of loss of confidence in the physician-patient relationship. Patients often feel their own physician may have chosen an inappropriate drug or not be capable of treating their particular problem. The physician may feel the patient is non-compliant with his advice and not taking his medication.

Adjunctive therapy may be useful in treating UTI's or preventing the recurrence of a previous infection. Personal hygiene must be stressed to all these patients. The question of concomitant hydration is a theoretical one. Increased fluid intake may enhance the clearing of bacteria from the bladder and produce rapid bacterial dilution. Unfortunately antibiotic concentrations in the urine are simultaneously being decreased with resulting less killing potential for the antibiotic. Large volumes of fluid in the urinary tract may possibly assist the bacteria to reflux further upwards in renal tissue and possibly producing a more serious pyelonephritis or other infectious involvement of the renal tissues. Water diuresis also increases urinary pH which is favorable to some bacterial growth. The use of vitamin C has traditionally been used to lower urine pH and inhibit bacterial growth but its actual ability to do this is debatable.

The most common organism identified microbiologically is *Escherichia coli* in outpatients and in the hospitalized patient. Various other gram-negative organisms are second in line for the most common offender pathogen. Gram-positive organisms can be seen but anaerobic organisms are much more rare. *Candida* species are the most common of the fungi seen in UTI's but are more frequently observed in the hospitalized patient who has been administered broad-spectrum antibiotics or who is immunosuppressed or complicated in some way. Initial UTI's in the hospitalized patient and the outpatient differ in the sensitivity to the antibiotics the physician would normally use. The hospitalized patient's infecting organism will tend to be more resistant due to the frequent exposure of the organisms to antibiotic and more difficult to treat because they often are the "complicated" variety or associated with an indwelling urinary catheter.

There are numerous antibiotics on the market to choose from, many of which are specifically aimed at the UTI. The ideal choice of antibiotic would be one that is inexpensive, has few side effects and has a low potential for organisms to develop resistance. For most initial UTI's a short-acting sulfonamide is often chosen due to their effectiveness with the common infecting organisms and little chance of existing resistance of the bacteria to the drug. Other common first-line urinary antibiotics include nitrofurantoin and nalidixic acid.

The sulfonamides are usually effective in an initial acute episode; but with recurrence they are often ineffective due to the rendering of fecal bacteria resistance. The cost of these drugs are low which is an advantage compared to many newer antimicrobials. Drug rash and nausea are relatively frequent with more serious problems such as bone marrow depression seen on a less frequent basis.

The tetracyclines are most effective in an acid urine pH. Pregnant women have a high incidence of UTI's, but the use during pregnancy must be avoided due to impaired fetal bone growth and tooth staining. Also cases of fatal drug induced hepatitis have been reported in pregnant women. Like the sulfonamides, tetracyclines have a tendency to select resistant strains of organisms due to high stool concentrations. As mentioned earlier, minocycline and doxycycline are especially useful in prostatitis due to their high lipid solubility and ease of entry into the prostate.

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URINARY TRACT INFECTIONS

Nalidixic acid, oxolinic acid and cinoxacin have no requirement for urine pH adjustment for efficacy. Various toxicities with these drugs include GI upset, visual disturbances, toxic psychosis and a G6PD-deficient hemolytic anemia. Resistance develops readily in the laboratory but it is questionable whether this occurs in actual clinical situations at therapeutic doses.

Little nitrofurantoin enters the stool so there is less chance of the development of resistance. The drug has optimal activity in an acidic pH and is effective in upper and lower UTI's. The major problem with its use is nausea and vomiting which can be eliminated by the use of the macrocystalline form at a higher cost to the pharmacist and patient.

One of the most popular antibiotics in the trimethoprim-sulfamethoxazole combination. The combination of these two drugs were chosen due to their similar half-life, synergistic effects, little chance of the development of resistance and broad spectrum. Excellent prostate and vaginal trimethoprim concentrations can be achieved thus being useful in infections involving bacteria thought to be originating from these areas.

Methenamine requires an acidic pH and a long residence time in the bladder to be effective. No susceptibility testing is required due to its mode of action. It is converted in the bladder to formaldehyde which kills virtually all pathogens. This drug may have usefulness in long term prophylaxis. A commercial product is available which is a hippuric acid salt which may aid in maintaining a low urinary pH which is required for the drug's activity.

Ampicillin, amoxicillin and carbenicillin are the penicillins commonly used. All these drugs achieve high urine concentrations. Ampicillin is very inexpensive and initially effective which makes it a wise first choice. Carbenicillin is useful for *Pseudomonas* infections which many other oral antibiotics are not effective against. All include the possibility of rashes or more severe allergic reactions.

Antibiotic therapy must be individualized for each patient and circumstance. The availability of such a large number of agents makes this possible and convenient. Although the urinary tract infection is an extremely common problem it is a potentially serious one. The pharmacist's responsibilities are important in helping the physician in the proper drug selection for the patient's individual characteristics, making the patient aware of possible adverse reactions and to encourage compliance.

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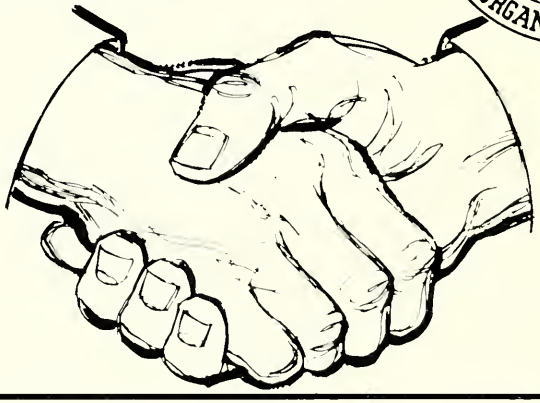

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NEW MEMBERS

Welcome to these pharmacists who have joined the NCPhA since the first of the year, and who, through their participation in organized pharmacy, help to elevate their profession.

Absher, Randall K., Greensboro
Adcock, Randy, Fuquay-Varina
Allen, Michael D., Winston-Salem
Anenone, James, Dobbs Ferry
Archbell, Stephen B., Rocky Mount
Ashworth, Paul, Cary
Ballard, David, Boonville
Bass, J. Joe, Faison
Beaver, Sr., Donald W., Concord
Becker, Stuart, Harrisburg, PA
L. Paige Blackman, High Point
Bland, Doug, Greensboro
Boggs, Karen, Charlotte
Bowen, Katrina Sue, Raleigh
Brauer, Philip D., Lexington
Brown, Hunter C., Rocky Mount
Buff, Norris F., Hickory
Calverly, Sue, Raleigh
Carpenter, Larry C., Morganton
Carringer, Laura Banner, Chapel Hill
Chitty, Catherine, New Bern
Clevenger, Brent, Washington
Cooke, Lucius, Statesville
Crawley, Douglas, Chapel Hill
Crew, Carroll Anna, Greenville
Crowell, Jr., Joe, Charlotte
Thomas D'Andrea, Red Springs
Davies, W. R., Lansdale, PA
Davis, Gary Mark, Lexington
Deaton, J. F., Liberty
Decker, Susan R., Greensboro
Dempsey, Paul Wesley, Clinton
Eubank, Dorothy, Selma
Evans, Wendell L., Eden
Farris, Wayne Clark, Charlotte
Fulton, Jr., Thomas A., Pittsboro
Furr, Stephen, Greenville
Galloway, Susan, Greenville
Greene, Ronald P., Chapel Hill
Griffin, Earl L., Durham
Hagemen, Robert E., Youngstown, Ohio
Hall, Tammy Coble, Burlington
Hardman, Diana L., Winston-Salem
Helms, J. Donald, Monroe
Hill, G. Earl, Kinston
Hinson, Jr., John L., Goldsboro
Hollowell, Linda A., Durham
Horton, Anne, Roanoke, VA
Howell, A. Griffith, Chapel Hill
Humphries, Bradley A., Camden
Hurwitz, Jean, Durham
Johnson, Karen E., Charlotte
Kendrick, Cheryl D., Greensboro
Koontz, Catherine C., Lexington
Koontz, Stephen Lee, Lexington
Krahulec, James, Harrisburg, PA
Langdon, Susanne V., Charlotte
Langdon, Timothy R., Chapel Hill
Lee, Jr., W. Homer, Benson
Locklear, Eric P., Gallup, New Mexico
McCary, R. Leslie, Fayetteville
McCaskill, Gail, Carthage
McGowan, David F., Chapel Hill
McLeaod, Laura Jean, Winston-Salem
McNeill, Martha F., St. Pauls
McSwain, David S., Gastonia
Malion, Jr., H., Fairmont
Matheson, Charles E., Marion
Meadows, Jr., David V., Charleston, W. VA
Miller, Alan, Statesville
Moody, Jr., David S., Durham
Naylor, Jr., Olen C., Greenville
Nebrat, Jack M., Durham
Nobs, Robert W., Jacksonville, Fla.
Owens, David, Fayetteville
Parker, Eric McFee, Candler
Rice, Charles D., Madison
Riddick, Bart, Aulander
Rubish, Andrew J., Denton

(continued on page 29)

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Sadek, Nagwa M., Chapel Hill
Sanders, Patsy B., Granite Quarry
Sampson, Karen G., Goldsboro
Saunders, Jr., Joseph A., Fayetteville
Shelton, Larry J., Hendersonville
Shoemaker, William P., Eden
Shotsberger, Jack, Morehead City
Singletary, Blenda, Iron Station
Slade, Ann, Raleigh
Smith, Cramer L., Lillington
Spears, Jr., V. A., Anderson, SC
Stamey, Robert K., Newton
Stansell, James L., Winston-Salem
Streng, Irene Carraway, Gastonia
Strickland, Jenny Lynn, Clinton
Stupalsky, Helen E., Mooresville
Tabb, Sharon G., Greenville
Taylor, Donna K., Snow Hill
Taylor, James M., Durham
Thorndyke, Andy, Laurinburg
Travis, Jo M., Raleigh
Trentadue, Gina, High Point
Upshaw, Constance S., Raleigh
Vinson, J. Stephen, Zebulon
West, Marquita, Oxford
Wierzbicki, Joseph E., Roanoke Rapids
White, Paul M., Whiteville
Wokasch, Mary J., Raleigh
Worthington, Patricia K., Ayden
Wozniak, Leon A., Utica, Michigan
Wuycik, Daria, Salisbury

COLLECTORS NOT SCARY DEBTS ARE

How would you react if you received a call from a collection agency? If you're like most people, you'd probably feel fear. But fear of what or whom?

Jean Rauchwarter, an I. C. System employee, explains that in doing collection work, it helps to understand the pressure debtors feel. "When you owe a bill and are not paying it, you're afraid," she said. "And whatever you're afraid of, you don't like," she added.

I. C. System employees, like Jean, know that most people are not really frightened by collectors; rather, it is their debts which scare them.

DRUGS CONTINUE TO DECLINE AS FACTOR IN HEALTH CARE COSTS

Drugs, often called the most cost-effective form of therapy, continue to take an ever-smaller share of the health care dollar, Department of Health and Human Services statistics show.

Drugs and drug sundries accounted for only 7.5% (or $21.4 billion) of the $286.6 billion spent on the nation's health in 1981, HHS's Health Care financing Administration finds. In 1980, drugs and drug sundries accounted for 7.75% of the total. In 1979 it was 8.0%; in 1978, 8.15%; and in 1977, 8.23%.

These items accounted for an even smaller share of the Medicaid budget, HCFA finds—$1.7 billion or 5.4% of the program's $31.3 billion budget from both state and federal sources last year. This compares with $1.4 billion spent on Medicaid drugs and sundries in 1980, representing 5.2% of the $26.8 billion Medicaid total.

"Personal care items," which reflect only amounts spent directly for health goods and services and do not include the costs of administration, government anti-smoking campaigns, research, and the like, show that 8.4% of this $255 billion total was spent on drugs and drug sundries in 1981, compared to a 8.8% in 1980.

All these HCFA figures include monies spent by government agencies, third-party payors, and private individuals. They represent the latest in an annual HCFA series of reports which began in 1964 and which are, according to the agency, "the most complete compilation of health expenditures available."

The full report will appear in the September 1982 Health Care Financing Review (Volume 4, Number 1). It will be available next month at $4 a copy from the superintendent of Documents, US Government Printing Offices, Washington, DC 20402.

SMITH APPOINTED TO STATE COMMISSION

Alfred Gene Smith, Elizabethtown, has been appointed to the Commission for Mental Health, Mental Retardation and Substance Abuse Services by Speaker of the House Liston B. Ramsey. Smith's appointment was effective July 6, 1982 and expires June 30, 1983. The Commission replaces the former NC Drug Commission and others. The other pharmacist on this important commission is Ms. Anita Gause, Roanoke Rapids.

MEDICAID PRESCRIPTIONS

Medicaid prescriptions have reduced their share of all dispensed Rxs, Pharmaceutical Data Services finds. PDS says Medicaid prescriptions dispensed last month represented only 12.2% of retail market, compared with 15.6% June 1981. Private third-party reimbursed prescriptions rose 0.8%, from 8.1% of total to 8.9%. Cash sales rose 2.6%, from 76.3% of all retail prescriptions in June 1981 to 78.9% last month. For first six months of 1982, 4.2% fewer prescriptions of all types were filled than in comparable period.

Karol Krueger of Conover, N. C. monitors the operation of an automatic capsule filling machine in the manufacturing department of A. H. Robins Company, Richmond-based pharmaceutical manufacturer. The rising senior at the University of North Carolina's School of Pharmacy is spending 10 weeks at Robins as a participant in the National Pharmaceutical Council—Pharmaceutical Industry Summer Internship Program (see news release).

UNC PHARMACY STUDENT PARTICIPATING IN SUMMER INTERNSHIP PROGRAM

Karol Krueger, a rising senior at the University of North Carolina's School of Pharmacy, is spending her summer at A. H. Robins Company as a participant in the National Pharmaceutical Council—Pharmaceutical Industry Summer Internship Program.

The Richmond-based company is one of 22 pharmaceutical manufacturers participating in the program conceived by the NPC and the Student American Pharmaceutical Association (SAPHA).

Now in its 10th year, the program is intended primarily as a learning experience that will add to the participating students' overall knowledge of pharmacy, with emphasis on its industrial aspects.

Krueger, a resident of Conover, N. C. (211 Second Ave. N.E.), is one of 87 students selected from 459 applicants from 46 schools to take part in the 1982 program.

Each participating company sets up its own program with most consisting of rotating assignments offering professionally-supervised hands-on experience in several departments. By the time Krueger leaves Robins at the end of this month, she will have worked 10 weeks in such areas as research and development, quality assurance, production and marketing. She is being paid a salary commensurate with those paid interns in other types of practice.

Krueger, who learned of the Internship Program from a fellow student who participated last year, applied because "I wanted to see firsthand what opportunities there are in industry."

In addition to making her more aware of the many jobs pharmacists perform in industry, she says "I have a much better understanding now of how a pharmaceutical product gets on the drugstore shelf, of all the things that go into producing a product."

Krueger will use the experience gained at Robins to help decide which aspect of pharmacy she will pursue following graduation.

At the University of North Carolina, she is a Dean's List student and a member of Rho Chi, honorary pharmaceutical society. She also is treasurer of the UNC chapter of the Student American Pharmaceutical Association.

BLAZING A NEW HORIZON: PHARMACY TECHNOLOGY

As health professionals and consumers alike demand improvements in quality of health care, we are confronted with the need to train supportive personnel to assist health professionals in meeting that need. The pharmacy profession is no exception. A new breed of "paraprofessionals" is surfacing to become the "extra hands" of the pharmacist. Supportive personnel are now being trained at Fayetteville Technical Institute, Durham Technical Institute, and Lenoir Community College. Fayetteville Technical Institute offers an Associate Degree in Applied Sciences in Pharmacy Technology upon completion of the two-year curriculum. Information regarding the one-year programs may be requested from the other institutions.

Recognizing a need to train assistants to pharmacists, F.T.I. launched a Pharmacy Technology Program in 1979. The curriculum requires two years of study during which students are introduced to all aspects of the pharmacy profession. They are provided a "working" knowledge of medical terminology, pharmacology, pharmaceutical calculations, extemporaneous preparations, pharmacy management, and manufacturing and quality control procedures, as well as all aspects of pharmacy law. Through the combined efforts of local hospitals and retail pharmacies, second-year students are given ten-week rotations in both hospital and retail pharmacies.

Students also tour at least two drug manufacturing firms in the state to obtain first-hand knowledge of manufacturing and quality control.

Pharmacy technology graduates may be employed by hospitals, nursing care centers, private and chain retail stores, drug manufacturers or wholesale drug companies. The curriculum also prepares the student to continue his education at higher levels in college or university settings.

We are proud of our graduates as well as our curriculum and look forward to a bright future for this new profession. We invite inquiries and would welcome visits to our campus.

Ellon Barlow, Department Chairman and Instructor
Mary J. Williford, Instructor
F.T.I.
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Fayetteville, NC 28303

About the Instructors:

Ellon S. Barlow is a 1967 graduate of U.N.C. School of Pharmacy and is now a resident of Fayetteville, North Carolina.

Mary J. Williford is a 1965 U.N.C. School of Pharmacy graduate and lives in Johnston County near Smithfield.

SKIPPER LLOYD SAILS AGAIN

Once again that intrepid pharmacist from Hillsborough, Evelyn Lloyd, has spent a few days aboard a wind-powered vessel in an exotic clime.

Staying at the exclusive "Club Mediterranee" in Ixtapa, Mexico, Lloyd sailed the warm waters of the Pacific as master of her ship, certainly a tribute to her skill and experience. She felt she learned much by sailing alone, but denied picking up any salty sea language. Captain Bligh Lloyd has returned home looking forward to her next excursion on the high seas.

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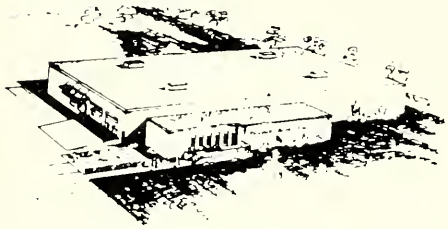

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ABBOTT

Charisse Krauth has been newly assigned to the Greensboro, North Carolina territory to represent Abbott Laboratories, Pharmaceutical Products Division. She has recently completed four weeks of initial training, most of which was spent in Abbott Laboratories' sales training facilities in North Chicago, Illinois. Charisse graduated from Syracuse University with a B.A. in Social Science Education.

MOORE COUNTY

1982-1983 officers of the newly organized Moore County Pharmaceutical Association are:

President—Hal Reaves, Jr.
Vice-President/Pres. Elect—John Barringer
Treasurer—Richard A. Knight
Secretary—Janet L. Musten

Board of Directors:
Kester Woody
Lewis Cooper
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3. Evaluate audit results and report to proper individuals.
4. Make contact with hospitals, and other providers of medical service when necessary to resolve problems.
5. Develop screening parameters that can be used with our PACE Claim System to alert us to potential overcharges, or inappropriate use of medical services.
6. Make contact with Professional Standard Review Organizations, and others who are concerned with cost and level of medical care, and its necessity, and work with these groups toward common goals.
7. Prepare claim cost control reports, and disseminate this data to policyholders, and cost control agencies.

This unit has been staffed by experienced people. The Coordinator, Mrs. Donna Newton, has fourteen years experience in health insurance, and health administration fields. This experience included health care provider relations, auditing hospitals for compliance with standard acceptable procedures, and working in a university affiliated medical center. Other members of the staff are experienced claim auditors.

We feel this is another positive step by Pilot Life to give needed service to our customers.

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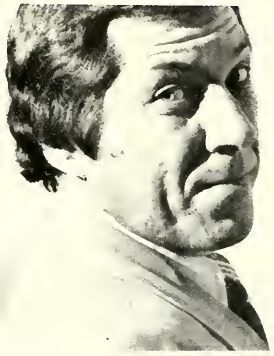

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BIRTHS, MARRIAGES & DEATHS

BIRTHS

Michale and Pamela Joyner, Raleigh are happy to announce the birth of their son David Andrew on May 23rd. He arrived at 1:10 p.m. and weighed in at seven pounds and two ounces.

MARRIAGES

Tracy Marie Fox and *Stephen Richards Furr* were married Saturday, July 10 in the Davis Street United Methodist Church in Burlington. A reception followed at the home of the bride's parents.

The bride graduated from the University of North Carolina at Chapel Hill and will start Graduate School at ECU in the fall. Mrs. Furr was formerly employed as a secretary for the NCPhA at the Institute of Pharmacy.

The groom is a 1982 graduate of the University of North Carolina at Chapel Hill School of Pharmacy and is employed by Pitt County Memorial Hospital. The couple will reside in Greenville.

DEATHS

T. M. (Tom) Stanback

T. M. Stanback, Salisbury, co-founder of the Stanback Company, died June 21, 1982 at the age of 97. A graduate of the Medical College of Virginia, Stanback and his brother Fred formed a partnership in 1924 and began actively promoting the headache remedy they had been selling for a few years. Stanback was active in civic affairs and benefitted many local charities and colleges.

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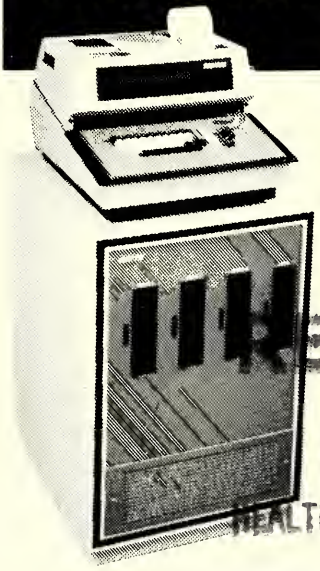

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SEPTEMBER 1982 VOLUME 62 NUMBER 9

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W. Thomas Boone, left, receives the Mortar-and-Pestle Award as 1982 Pharmacist of the Year from immediate past president J. Marshall Sasser. photo by Colorcraft.

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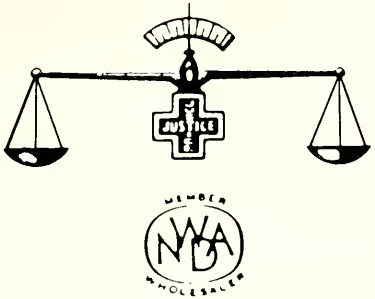

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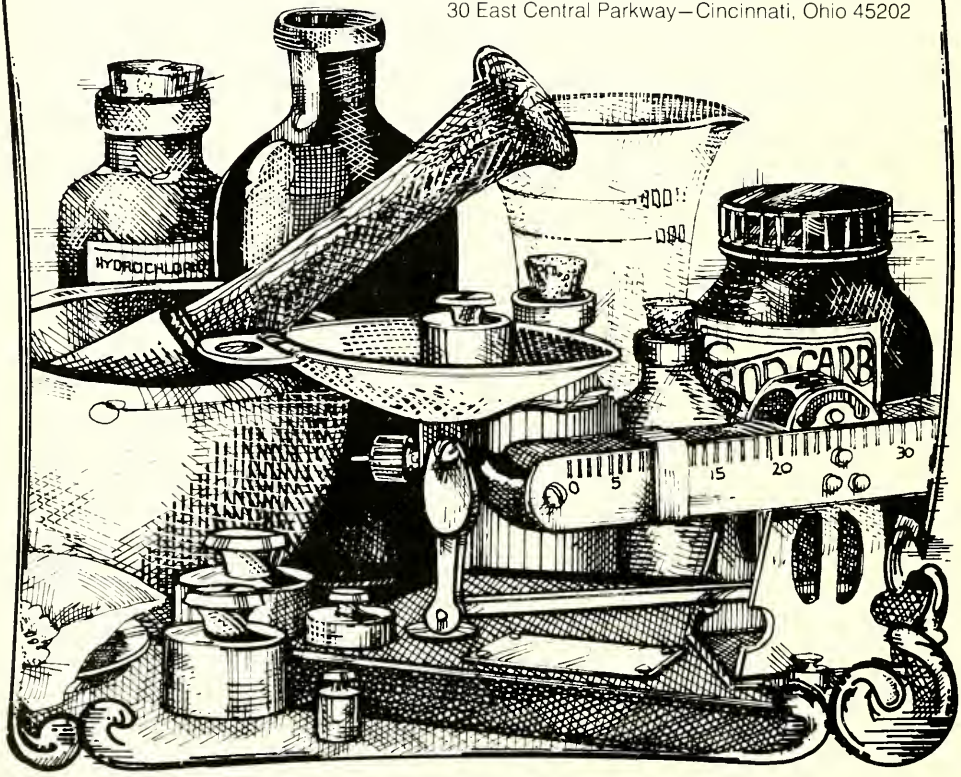

THE CAROLINA JOURNAL of PHARMACY

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SEPTEMBER 1982 VOLUME 62 NUMBER 9

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Our best friends are our severest critics and our greatest assets.

Meet our 1982 Pharmacy Consultant Panel.

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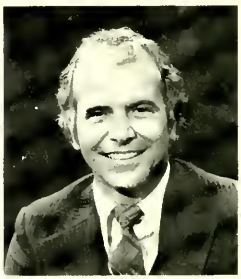

Lawrence A. Diaz, R.Ph.
Community Pharmacist
Gainesville, Florida

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TOM BOONE HONORED AS PHARMACIST-OF-THE-YEAR

William Thomas (Tom) Boone, Ahoskie, was honored by friends, neighbors and professional associates as the 1982 North Carolina Pharmaceutical Association Pharmacist-of-the-Year, at a dinner held in Ahoskie, Friday night, July 23.

Presiding at the dinner and awards ceremony was NCPhA president Ernest J. Rabil, Winston-Salem, who told the more than 175 persons attending the dinner that Boone received the coveted Mortar-and-Pestle award for outstanding service to his community, and his profession for many years. The award is the most prestigous award bestowed by the pharmaceutical association on a member and Boone joins an elite list of pharmacists who have been prior recipients. Among the past recipients at the ceremony were John Stevenson, Harold Day, Jimmy Creech, John Henley, J. C. Jackson, Hoy Moose, B. R. Ward and June West.

Program participants who related their experiences with Boone were Rev. Robert M. Poulk, minister of the Ahoskie Methodist Church; Dr. J. L. Darden, Jr., family practitioner; and W. J. Smith, retired executive director, NC. Pharmaceutical Association. Rev. Poulk related some of the involvement of Boone in the church and was pleased the profession had recognized Boone in this way. Dr. Darden roasted Boone but concluded his remarks by saying "Boone has served the pharmaceutical association well. If you look at the printed program, you will see his contributions to his profession." Smith said "Boone has established a distinguished record in his profession and civic affairs." "He operated a traditional pharmacy for years but realized he was not providing service to its potential." He has been a pioneer in developing new pharmaceutical systems throughout the state," and was among the first to establish a drug-patient record system.

In the community, Boone has been a member of the town council and served as mayor protem. He is a director of the Ahoskie Chamber of Commerce and is a former member of the Ahoskie Development and Industrial Committee. He is a member, and past president of the local Kiwanis Club, a Boy Scout Committeeman and former president of the PTA.

Katherine and Tom Boone, with NCPhA President Ernest Rabil.
Photo by Colorcraft

He is a past chairman of the Ahoskie Methodist Church Board of Stewards and served on the Finance and Stewardship Committee and the Committee for Christian Social Concerns. Boone graduated from UNC School of Pharmacy in 1943 and is the owner of Boone's Professional Pharmacy. He is a past-president of the North Carolina Pharmaceutical Association, a member of the American College of Apothecaries, the American Pharmaceutical Association, the National Association of Retail Druggists, and was recently elected to serve as director of the North Carolina Pharmaceutical Research Foundation. He is a member of the North Carolina Academy of Pharmacy and a past president of the Northeastern Carolina Pharmaceutical Society.

Boone is married to the former Katherine Hardison of Weldon, and they have a son, William Thomas Boone, Jr., Washington, and two daughters, Mary Katherine Coan, Matthews, and Laura Ann Ward, Southern Pines.

The Mortar-and-Pestle Award was presented to Boone by J. Marshall Sasser, Smithfield, immediate past president of the NCPhA. A warm welcome to the city was given by Ahoskie Mayor Merrill Evans.

Former recipients of the Mortar and Pestle Award; Seated J. C. Jackson and Hoy A. Moose. Standing, John Stevenson, Harold V. Day, 1982 recipient W. Thomas Boone, Jean B. Provo, James Creech, B. R. Ward and John T. Henley. photo by Colorcraft.

Program participants: Left to right, Dr. J. L. Darden, MD, Reverend Robert M. Poulk, W. Thomas Boone, J. Marshall Sasser, W. J. Smith and NCPhA President Ernest J. Rabil. photo by Colorcraft.

CHARLOTTE WOMAN'S PHARMACEUTICAL AUXILIARY

The Charlotte Woman's Pharmaceutical Auxiliary met October 12, 1982 at "Comos Steak House" on Independence Blvd. for a luncheon meeting.

Mrs. Leslie H. Davis, first vice president presided in the absence of the president, Mrs. E. C. Anselment, who has had to resign due to illness.

Mrs. W. D. Smith, Chairperson of the nominating committee reported that Mrs. C. H. Smith would be acting President for the November and December meetings. Mrs. L. H. Davis, first vice president will assume the presidency in January.

The Sunshine chairperson, Mrs. H. L. Bizzell urged members to send cards to Grover and Margaret Smith to let them know we support them in the troubled time of Grover's recuperation.

Sharon Hedrick of "Frames and Things" gave a delightful program on what to do with your sentimental treasures, such as old photographs, baby things, graduation certificates and etc.

The 12th Annual Holiday Bazaar will be held at the November meeting. Everyone is urged to make it the best one ever. Mrs. W. K. Gardner is in charge of the Bazaar.

Mercer H. Smith

LOAN FUND CONTRIBUTION

A contribution to the NCPhA Consolidated Student Loan Fund in honor of Mr. I. J. Pruett, Angier has been made by the Harnet County Pharmaceutical Association. Mr. Pruett, a long-time member of the local association, has recently retired.

Al Mebane, Executive Director, at the controls of the recently purchased Apple III computer now used to manage membership mailing lists.

Photo by Colorcraft

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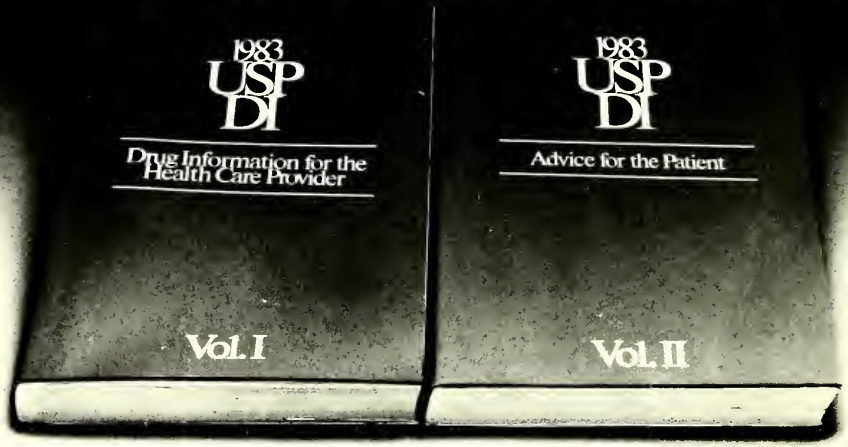

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CONSTITUTION AND BY-LAWS
OF THE
North Carolina Pharmaceutical Association

Article I—Name

This Association shall be called "The North Carolina Pharmaceutical Association."

Article II—Object

The purpose of this Association shall be to protect the public health and welfare by uniting the pharmacists of this state for the advancement of their profession; to improve the art of pharmacy and to evaluate its standards; to restrict the dispensing and sale of medicines to pharmacists; to encourage and promote research and study; to interest competent individuals in the practice of pharmacy as a career; to foster a system of pharmaceutical education and continuation studies; to encourage research and training for all phases of the practice of pharmacy as a means of providing the greatest protection for the public at large; to advance pharmaceutical education and support scholarships in education in pharmacy; to publish and disseminate useful knowledge; to establish and maintain high ethical standards of professional conduct and practices; to promote and encourage relations of good will and respect between pharmacists and other health professions and the public; and to promote mutual cooperation of these disciplines so as to extend their usefulness of the public.

Article III—Membership

This Association shall consist of Active, Life, Student Branch and Honorary Members.

Section 1. ACTIVE MEMBERS. An active member shall be any pharmacist of good moral standing who is registered under the Pharmacy Law of this state with a current renewal certificate and who has paid the annual dues as specified in the By-Laws. Whenever an active member ceases to be a registered pharmacist of this state with a current renewal of registration, his active membership shall terminate unless extended by action of the Executive Committee.

Section 2. LIFE MEMBERS. Any active member who has previously been declared a life member or who qualifies for life membership as specified in the By-Laws shall be exempted from further payment of dues.

Section 3. STUDENT BRANCH MEMBERS. Students enrolled in a School of Pharmacy within the limits of the state, are eligible for membership in the Student Branch of the N. C. Pharmaceutical Association at the annual membership fee as specified in the By-Laws of this Association. Members of the Student Branch shall not have the privilege of voting or holding office but shall be entitled to all other rights of membership.

Section 4. HONORARY MEMBERS. Any person whose contribution to Pharmacy, or whose knowledge of Pharmacy and the Colateral Sciences shall, in the opinion of the Association, merit that distinction, may upon nomination by the NCPhA Executive Committee be elected an Honorary Member. Honorary Members shall be exempted from the payment of dues; they shall receive the publications of the Association, but they shall not have the right to vote or to hold office in the Association.

Article IV—Officers

The Association shall have the following officers; a President, a First Vice-President who shall be President-Elect; a Second Vice-President; a Third Vice-President; and a Secretary-Treasurer.

The three Vice-Presidents shall be elected annually by mail ballot and shall hold office until their successors are elected and have qualified. The First Vice-President (President-Elect) shall automatically assume the office of Presidency without being subject to further election.

The President, the three ranking Vice-Presidents, and the Secretary-Treasurer shall be ex-officio members of the Executive Committee. Each retiring President shall be a member of the Executive Committee for a three-year term.

Article V—Amending Constitution

Every proposition to alter or amend this Constitution shall be submitted in writing and received at an annual meeting, and may be voted on at the next annual meeting when, upon receiving a vote of three-fourths of the members present, it shall become a part of the Constitution of the North Carolina Pharmaceutical Association.

(continued on page 11)

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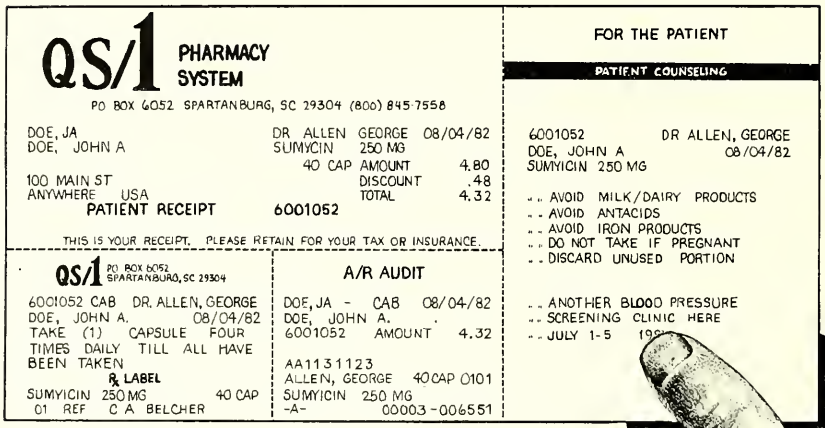

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BY-LAWS

Article I—Election of Officers

Section 1. A Nominating Committee of seven members shall be annually chosen by the President and charged with the duty of selecting candidates for the offices of first, second, and third vice-presidents, and three members-at-large of the Executive Committee of the N. C. Pharmaceutical Association; one member of the North Carolina Board of Pharmacy; and four Directors of the North Carolina Pharmaceutical Research Foundation, Inc.

Section 2. The Nominating Committee shall submit at the last session of each annual convention the names of two or more persons or candidates for each of the offices of First Vice-President (President-Elect), Second Vice-President, Third Vice-President; six persons for three places as members-at-large of the Executive Committee; two or more persons for members of the North Carolina Board of Pharmacy; eight or more persons as candidates for four directorships of the N. C. Pharmaceutical Research Foundation, Inc. Additional nominations may be made from the floor.

Section 3. No less than thirty days prior to the annual convention, the president of the Association shall select a committee of three pharmacists from the district of the member of the Board of Pharmacy whose term expires the following year. It shall be the duty of this committee to recommend two candidates from their district to the NCPhA Nominating Committee for membership on the Board of Pharmacy. The recommendation of the district committee shall be final unless altered by a majority vote of members present and voting at a meeting of the Nominating Committee. Candidates for membership on the Board of Pharmacy may be nominated from the floor, but such nominees must practice pharmacy in the district entitled to the nomination.

Section 4. The names of the candidates so nominated shall be submitted by the Secretary-Treasurer by mail to every member of the Association within one month after he receives them, together with the request that the members indicate their preference on a ballot enclosed for that purpose, and return the same by mail within one month.

The ballots received as indicated in the preceding paragraph are to be sent to an "Election Committee" in care of the Secretary-Treasurer, Chapel Hill. The Election Committee shall consist of four members, each selected by mail ballot for a term of three years. The Election Committee shall count as votes in the annual election only those ballots received from members whose dues have been paid for the current year. The Election Committee shall certify to the Secretary-Treasurer the results of the tally after which the latter shall be published.

The Secretary-Treasurer shall notify all candidates of the time and place of the meeting of the Election Committee and extend a written invitation to attend the counting of the ballots.

Section 5. The officers thus elected by a plurality of the votes shall be installed at the final session of the next annual meeting.

Article II—Duties of Officers

Section 1. THE PRESIDENT. The President shall preside at all meetings of the Association, enforce a due observance of the provisions of the Constitution and By-Laws and parliamentary proceedings; he shall appoint all committees and delegates not otherwise provided for or ordered by the Association; he shall be ex officio member of all committees and delegations; he shall fill by appointment all vacancies occurring in office excepting the offices of vice-presidents, and also occurring in committees and the Executive Committee by reason of death, resignation, or inability to act; he shall be chairman of the Executive Committee; he shall present, at the annual session of the Association, a report upon the operations of the Association during his term of office, and an address upon which subjects as he may select and shall make such suggestions as he may deem suitable to promote the objects and welfare of the Association.

Section 2. THE VICE-PRESIDENT. (a) The First Vice-President shall be the president-elect of the Association, and a member of the Executive Committee. In the absence of the President, he shall perform the duties of that office. If the office of the President shall be vacated by reason of death, the First Vice-President shall become the President of the Association.

(continued on page 13)

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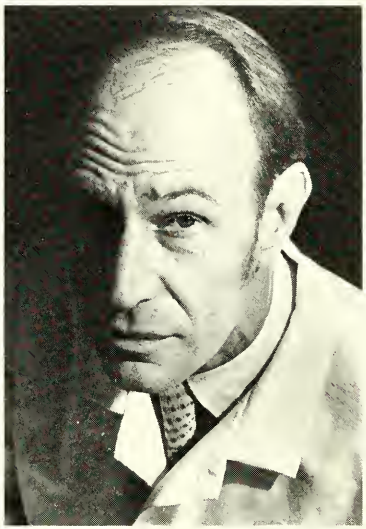

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(b) The Second Vice-President shall be a member of the Executive Committee. In the absence of the President and the First Vice-President, he shall perform the duties of the President. In the absence of the First Vice-President, he shall perform the duties of that officer. (c) The Third Vice-President shall be a member of the Executive Committee and in the absence of the President and the two vice-presidents, shall perform the duties of the President. (d) In the event that the office of the President-elect and/or Second or Third Vice-Presidents be vacated for any reason whatever, such office shall be filled only by special election.

Section 3. THE SECRETARY-TREASURER. The Secretary-Treasurer shall keep correct records of all proceedings of the Association; a list of the names, residence and date of administration of each member; he shall collect all dues and all other monies due the Association and shall promptly deposit same in such depositories as the Executive Committee shall designate; he shall conduct the official correspondence of the Association and notify each member by mail of the meetings; he shall make disbursements only as directed or outlined by the Executive Committee and maintain all records pertaining thereto; he shall carefully preserve all papers and archives of the Association; he shall edit and distribute the Carolina Journal of Pharmacy and the Proceedings of the Association; he shall act as secretary to all committees of the Association and he shall discharge such other duties as the Executive Committee shall assign to him. He shall be bonded by an indemnity bonding company for a sum not less than $10,000 and after approval of the Executive Committee, the fee for said bond being paid by the Association; he shall receive such annual salary as the Executive Committee may from time to time determine. A certified public accountant shall be engaged annually to audit the financial accounts of the Secretary-Treasurer.

Article III—Of Committees

Section 1. There shall be four standing committees: an Executive Committee in accordance with Subsection (a) of this Article; a Legislative Committee of seven members together with such nonvoting advisory members as the President may deem it wise to appoint; a nominating Committee in accordance with By-Laws Article I, Election of Officers; a Resolutions Committee of five members.

Subsection (a). THE EXECUTIVE COMMITTEE. The Executive Committee shall consist of the President, the First Vice-President, the Second Vice-President, the Third Vice-President, the Immediate Past-President, the Secretary-Treasurer, two past-presidents as provided in Article IV of the Constitution; and three elected members-at-large.

It shall be the duty of the Executive Committee to take into consideration and act upon all matters of business between annual meetings, and upon all propositions for membership; to approve all bonds protecting the funds of the Association; to select depositories in which the funds and securities of the Association are to be deposited; to direct the investments of funds of the Association; to contract for and make necessary arrangements for editing and publishing the Annual Proceedings, the Carolina Journal of Pharmacy, and such other publications as the Association may direct; and to perform such other duties as may from time to time be referred to it. It shall also have general charge of and final authority over all affairs of the Association which are not specifically provided for elsewhere in the By-Laws.

Subsection (b). THE LEGISLATIVE COMMITTEE. It shall be the duty of the Legislative Committee to use its efforts in sponsoring the passage of such legislation as the Association may specifically recommend, and to oppose such legislation as the Association resolves to oppose. During the intervals between annual meetings of the Association, if anticipated legislative developments occur, the Legislative Committee shall ask for a called meeting of the Executive Committee in order that the latter committee may act officially for the Association in advising, approving, or opposing such measures or methods as the Legislative Committee may present. This Committee may use its discretion in withholding any information which it deems unwise or unnecessary to publish. With this qualification, the report shall be presented to the Association by the Chairman of the Legislative Committee or his appointed representative.

(continued on page 14)

Subsection (c). THE RESOLUTIONS COMMITTEE. The Committee on Resolutions shall meet together and decide on matters upon which the organization should take a public stand. The Committee shall also receive all resolutions which may be referred to it by the Association members for study at any annual meeting, provided they are presented in writing to the committee no later than the first full day of the annual meeting if the meeting is scheduled for more than one day and no later than noon if the meeting is scheduled for one day only.

Section 2. APPOINTIVE COMMITTEES. The President shall appoint the following committees to be assigned applicable powers and duties, consistent with the Association's Constitution and By-Laws:

A. Continuing Education
B. Consolidated Pharmacy Loan Fund
C. Delivery of Pharmaceutical Service
D. Endowment Fund (NCPhA/Institute)
E. Hospital Pharmacy
F. Mental Health
G. Nursing Homes/Extended Care Facilities
H. Professional Relations
I. Public Relations
J. Public Health and Welfare
K. Social and Economic Relations

Other committees may be appointed by the President to perform such special duties as may be assigned by the President and/or the Executive Committee.

Article IV—Of Membership

Section 1. ACTIVE MEMBERS. Every pharmacist meeting the qualifications of Article III, Section I of the Constitution, or every graduate of an accredited school of pharmacy is eligible for active membership in the North Carolina Pharmaceutical Association. Applicant will complete membership form available from Association office, and submit together with annual dues in accordance with Sub-section (a).

Subsection (a). DUES. Every member shall pay in advance into the hands of the Secretary-Treasurer the sum of sixty dollars as yearly contribution, except those pharmacists residing out-of-state who shall pay thirty dollars. Pharmacists who are retired and on Social Security shall pay one-half the annual dues structure. Husband and wife pharmacists shall pay one and one-half the annual dues structure and shall receive one mailing, with the exception of Association mail elections, for which they shall each receive a ballot.

Subsection (b). NON-PAYMENT. Any member in arrears at any annual meeting shall not be entitled to vote; anyone neglecting to pay his annual dues shall lose his membership.

Section 2. LIFE MEMBERS. Any member in good standing is eligible for a life membership and thereafter he shall be exempt from all future annual dues. The cost of such membership shall be ten times the individual's maximum annual dues.

Also, the Executive Committee is empowered to vote into Life Membership a member whose contributions to his profession and/or the Association have been so outstanding that he merits this honor.

Section 3. STUDENT BRANCH. Any student in a School of Pharmacy meeting the qualifications of Article III, Section 3 of the Constitution, and paying the annual dues of one dollar is eligible for membership as specified in the above-named section.

Section 4. HONORARY MEMBERS. Honorary Membership may be conferred upon nonmembers who have made noteworthy contributions to the Association. Nomination for such honorary membership shall be made to the Executive Committee, who shall consider and act upon such nomination. Honorary members shall have the privilege of attending annual meetings of the Association but shall not enjoy any other rights or privileges of membership in the organization.

Article V—Of Meetings

Section 1. Association meetings shall be held annually, or from time to time, as the Association may determine, provided that in case of failure of this form any cause, the duty of calling the Association together shall devolve upon the President, or upon the Vice-Presidents, with the advice and consent of the Executive Committee.

Special meetings may be held upon written request of fifteen members, who shall state the purpose thereof, and only such matters shall be considered at such a meeting.

Section 2. At the opening of each annual meeting, in the absence of the President, or

Vice-President, one of the Executive Committee shall take the chair. In the absence of all, a President pro tempore shall be elected by the members present. In the absence of the Secretary-Treasurer, the presiding officer shall appoint a Secretary pro tempore.

Section 3. Fifty members constitute a quorum.

Section 4. REGISTRATION FEE. A registration fee shall be paid by each person participating in the affairs of the annual convention, except for student branch members. The amount of such fee shall be fixed annually by the Executive Committee.

Article VI—Of Branches

Section 1. There shall be a students' branch within the Association, the membership of which shall be composed of and limited to regularly enrolled students in a School of Pharmacy within the borders of North Carolina. The Branch must organize itself, elect a president, a secretary, and a treasurer. These officers shall be responsible to the Secretary-Treasurer of the Association for funds collected as annual Association dues. It shall have a constitution and set of by-laws which shall be approved by the Executive Committee of the Association.

No action taken by such Branch shall bind the Association in any way save when a proposed action is submitted as a recommendation to the Executive Committee prior to the annual meeting. If the Executive Committee gives its approval the recommendation may be submitted first to the general membership at a regular meeting and then assigned to the Committee on Resolutions for study and report in the usual manner.

Article VII—Of Delegates

Section 1. The President shall annually appoint two delegates to the American Pharmaceutical Association and two to the National Association of Retail Druggists.

Article VIII—Amending the By-Laws

Section 1. Every proposition to alter or amend these By-Laws shall be submitted in writing at one session of the annual meeting and shall be balloted on at a subsequent session when, upon receiving a vote of two-thirds of members present, it shall become part of the By-Laws.

Revised: January 1979

Dave McGowan, Assistant TMA Secretary-Treasurer, shown preparing a TMA Convention badge.
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ANTIPLATELET AGENTS

Bruce R. Canady, Pharm D.
AHEC Pharmacist, Wilmington AHEC and Clinical Assistant Professor
UNC School of Pharmacy and Department of Medicine
UNC School of Medicine

Introduction

Prior to a discussion of the mode of action and clinical use of antiplatelet agents, a brief, simplified review of the role of platelets in the clotting process may prove useful. The arachidonate pathway (Figure I) is the key to understanding the role of the platelet in hemostasis. Phospholipid, a constituent of cell membranes, is converted to arachidonic acid by the action of phospholipase A_2. Arachidonic acid is then converted by the enzyme cyclo-oxygenase to cyclic endoperoxides (PGG_2 and PGH_2). Here the process splits. In platelets these endoperoxides are converted by thromboxane synthetase to thromboxane A_2 (TXA_2) which is a potent vasoconstrictor and promotes platelet aggregation probably by inhibiting adenyl cyclase, decreasing cyclic AMP (cAMP) levels. Diminished cAMP decreases the activity of phosphokinases which phosphorylate protein substrates resulting in increased levels of cytoplasmic calcium, which in turn promotes irreversible platelet aggregation.[1] In cells lining vessel walls the cyclic endoperoxides are primarily converted by prostacyclin synthetase to prostacyclin (PGI_2), which elevates cAMP levels, thus inhibiting platelet function.[2,3,4,5]

It is probably this balance of TXA_2 and PGI_2 which defines platelet activity at a given moment. If vessel alteration occurs (i.e. trauma) the balance shifts in favor of coagulation. Platelets adhere to the defective area (i.e. collagen, basement membrane, etc.) and release adenosine diphosphate (ADP), which promotes primary aggregation (adhesion of platelets to each other) and initiates the arachidonate pathway. The activation of the platelet arachidonate pathway promotes the release reaction leading to irreversible aggregation and the release of platelet factor 4 and calcium. Platelet factor 4 (anti-heparin factor) and calcium play a significant role in initiating and maintaining the clotting cascade. As fibrin is formed, it deposits on and around the platelet plug forming the clot.

There are four drugs which have been most extensively evaluated with regard to their antiplatelet effects. They are aspirin, sulfinpyrazone, dipyridamole and clofibrate. In addition, the effect of hydroxychloroquine has been examined in venous thromboembolic problems. Each of these antiplatelet drugs affects the clotting scheme uniquely, thus each agent will be discussed individually.

Modes of Action

Aspirin inhibits platelet aggregation primarily by acetylating cyclo-oxygenase. This prevents the conversion of arachidonate to the cyclic endoperoxides.[6,7,8,9,10] While this occurs in both platelets and vessel walls and would be expected to produce little net change in aggregability, this is not the case.[11,12,13] The platelet, being a non-nucleated cell, cannot regenerate cyclo-oxygenase, thus, the resulting inhibition of aggregation is permanent.[7] In contrast, the cells of the vessel wall synthesize additional cyclo-oxygenase, thus resuming prostacyclin production and inhibiting platelet aggregation.[13,14,15] Doses as low as 160 mg/day will inhibit platelet cyclo-oxygenase by more than 80%.[6] Additionally, aspirin acetylates membrane proteins and inhibits the membrane enzyme collagen-glucosal transferase, which may also inhibit platelet function.[17] Aspirin will also prolong the bleeding time in doses of 300 mg and up.[18] Finally, it can also prolong the prothrombin time at doses of 1300 mg/day and up.[19].

Sulfinpyrazone appears to be a competitive inhibitor of cyclo-oxygenase.[20] Additionally, there is evidence that a metabolite exists which is more active than the parent compound and may produce more permanent cyclo-oxygenase inhibition.[21,22] Sulfinpyrazone may also normalize platelet survival in some conditions which routinely decrease it.[23,24,25,26,27]

Dipyridamole probably owes its activity to the inhibition of phosphodiesterase. This inhibition leads to an increased availability of cAMP which inhibits platelet function.[1,28,29] In addition, it inhibits the uptake of both glucose and adenosine by platelets as well as the binding of ADP to the platelet membrane.[30] There is also preliminary evidence of other mechanisms for dipyridamoles effect. The drug may stimulate prostacyclin release and then work synergistically with it to increase cAMP.[31, 32] Platelet prostaglandin production may also be inhibited.[33]

The mechanism by which clofibrate produces its antiplatelet activity is still poorly understood. Currently we attribute the effects of clofibrate to its weak antioxidant activity, although paradoxically, it has also been reported to decrease PGI_2 synthesis in human vessel walls.[34] Nonetheless, clofibrate does increase the reduced platelet survival associated with some cardiac diseases[35] and decreases the sensitivity of platelets to activating substances in patients with familial hyperbetalipoproteinemia.[36]

The mode of action of hydroxychloroquine remains a mystery. While ADP-induced aggregation is inhibited in vitro, no mechanism for its effects has been well demonstrated.

Clinical Use

Coronary artery disease. One of the most actively investigated areas of antiplatelet therapy is in coronary artery disease. It has never been conclusively shown that aspirin is of any value in preventing myocardial infarction or reinfarction, although several studies have identified trends in favor of aspirin,[37,38,39,40] particularly in male patients in whom aspirin treatment is begun within a few weeks of initial infarction.[41] Sulfinpyrazone (800 mg/day) has been shown to

(continued on page 23)

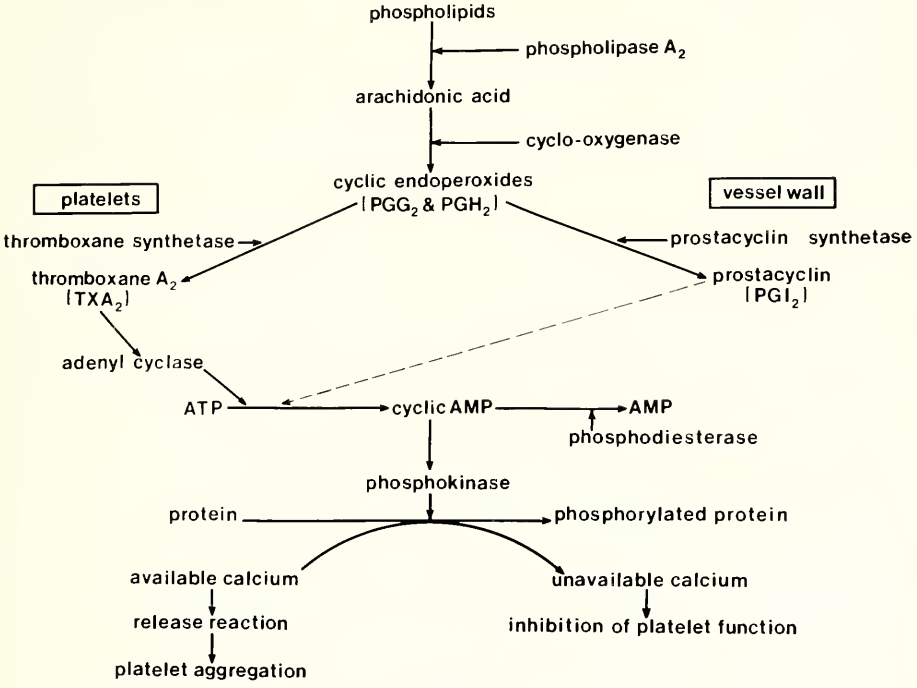
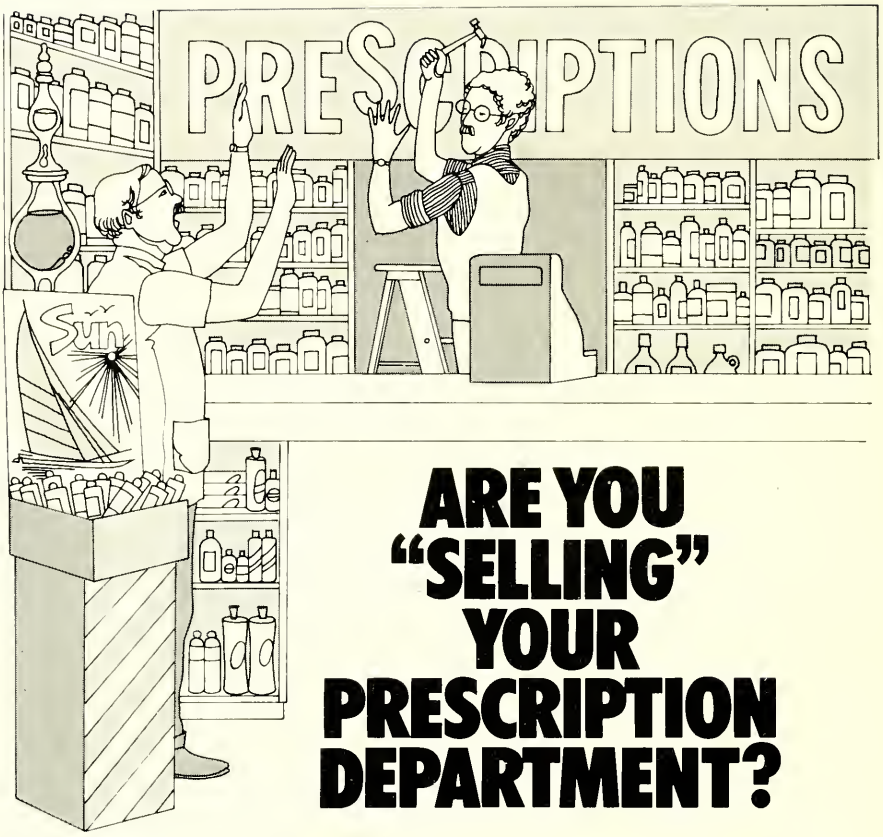


Figure I
Arachidonate Pathway



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reduce sudden death when treatment is begun approximately 30 days post-infarction.[42] Protection was conferred only through the seventh month after which time the morality rates for the treatment and control groups are equivalent.[43] No beneficial effect of dipyridamole has been demonstrated to date, nor have promising trends been noted, although some feel that a definitive study has not yet been done.[44] Clofibrate has also been investigated with essentially negative results.[45,46,47]

Cerebrovascular disease. The value of antiplatelet therapy in the prevention of transient ischemic attacks (TIA) and, cerebrovascular accidents (CVA), has been extensively evaluated. Aspirin (1200 mg/day) has been shown to be of value in reducing the incidence of TIA's in all patients, and of stroke and death in male patients. Those with carotid artery lesions producing multiple TIA's may be more likely to respond favorably.[48,49] No substantive data exists demonstrating reproducible efficacy for sulfinpyrazone, dipyridamole or clofibrate.

Postoperative Venous Thrombosis. The effect of antiplatelet agents on the incidence and severity of post-operative venous thromboembolism (VT) has been examined following general and orthopedic procedures. Aspirin (1300 mg per day) alone[50] and in combination with dipyridamole,[51,52] has shown some value in reducing the incidence of VT after general surgery, but the majority of the data is less encouraging.[53,54]

On the other hand, hydroxychloroquine (600-800 mg/day) seems to offer more promise. Several studies have demonstrated a significant reduction of deep VT following general procedures.[55,56,57] Following various orthopedic procedures, aspirin has been shown to be as good as warfarin,[58] superior to placebo in men only,[59] beneficial,[60] ineffective,[61] possibly detrimental,[62] and to exert a dose-dependent effect,[63] leaving substantial doubt as to aspirin's place following such procedures. The data supporting the use of hydroxychloroquine following orthopedic surgery is as confusing as that for aspirin, but is generally negative.[64,65,66] Sulfinpyrazone has not been shown to be of benefit,[67,68] while clofibrate has not been studied. The incidence of fatal pulmonary embolus occurring post-operatively has also been reduced by the administration of aspirin (1200 mg/day).[69]

Arteriovenous (AV) Shunts. Two drugs have been evaluated for their ability to improve the patency rate of arteriovenous (AV) shunts in hemodialysis patients. Aspirin (160 mg/day)[70] and sulfinpyrazone (600 mg/day)[71] have both demonstrated efficacy in this situation, decreasing the incidence of AV shunt thrombosis.

Prosthetic Heart Valves. Aspirin (1000 mg/day)[72] and dipyridamole (400 mg/day)[73] have been studied in patients with prosthetic heart valves. Either drug in combination with oral anticoagulants, has been shown to be more effective than oral anticoagulants alone in reducing the incidence of thromboembolic complications. Aspirin alone is probably not as effective as conventional oral anticoagulant therapy.[73]

Microcirculation. Aspirin (300-1000 mg/day)[74,75,76] has been shown to produce improved control of the syndrome of thrombocytosis and peripheral arterial ischemia.

Conclusions. Many questions remain unanswered about the use of antiplatelet agents. There is no standard *in vivo, ex vivo,* or *in vitro* test which can predict the performance of a given agent in a particular clinical situation, since each drug's performance is effected by the nature of a clotting stimulus as well as its own, unique, mechanism of action.[77] Even well designed clinical investigations can only evaluate the intervention of an agent or combination in a specific problem, and this application implies neither the utility of that drug for other platelet-medicated conditions nor the efficacy of other antiplatelet agents in that particular problem. Continued progress in antiplatelet therapy must come from (1) further elucidation of the role of platelets, prostaglandins, etc. in the coagulation process, (2) clarification of the mode of action of each antiplatelet agent, (3) synthesis of new agents to be used primarily for their antiplatelet effects and (4) large, well designed and conducted clinical investigations to determine the best agent for a given problem.

References available by writing the author at:

Mr. Bruce Cannaday
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KATHLEEN D'ACHILLE

on her appointment as Director of Pharmacy for the Winston-Salem Health Care Pharmacy. We are pleased to have been a part in the planning and completion of this pharmacy.

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Alec W. Clelland, Jr., Fayetteville, Ralph B. Caricofe, Pinehurst, and Jacquelin T. Harrell, Charlotte, have each won $1,000 in the Burroughs-Wellcome Pharmacy Education Program.

Five hundred dollars ($500) of each award will go to the pharmacy school of the winner's choice and a like amount will be presented to the education foundation of a national pharmacy organization. Clelland's award will go to the University of North Carolina and The National Association of Retail Druggists' educational foundation; Caricofe's award will be split between Ohio Northern University College of Pharmacy and the American Pharmaceutical Association's educational foundation; Harrell's award will be presented to the UNC School of Pharmacy and the APHA. Money awarded to the schools will be used to establish a revolving loan fund for needy, deserving pharmacy students.

The $156,000 Pharmacy Education Program is sponsored by Burroughs Wellcome Co., and attracted more than 45,000 entries from pharmacists across the nation. Three winners from each state, the District of Columbia and Puerto Rico were selected in a drawing held at the companies offices in Research Triangle Park, North Carolina.

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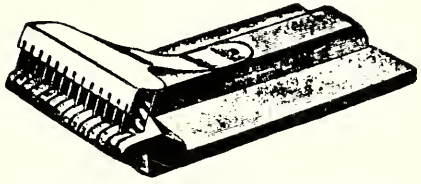
Van H. King, III, Wilmington, who has won $100.00 in the Drug Store News Nostalgia Quiz. Van says this is the first money he has ever won.



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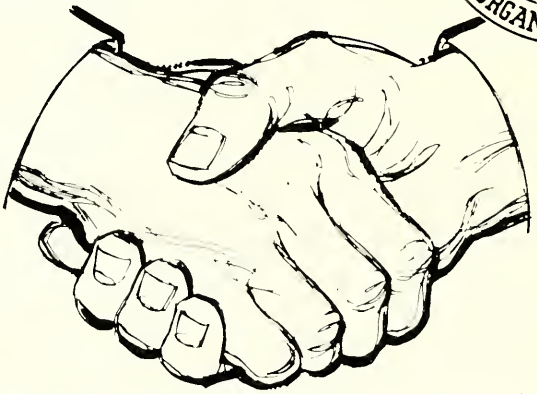

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APHA PUBLISHES SEVENTH EDITION OF HANDBOOK OF NONPRESCRIPTION DRUGS

The seventh edition of the highly respected *Handbook of Nonprescription Drugs* is off the presses and proving to be a best seller for its publisher, the American Pharmaceutical Association (APhA). "Initial sales of this important text have been especially gratifying," said APhA president William S. Apple, Ph.D.

Three years in the making, the new edition of the *Handbook* has been greatly expanded over its earlier editions. Its more than 700 pages include 34 chapters, 32 of which are devoted to specific groups of drug products and the disease states for which they would be used as treatment. Each of these 32 chapters either is entirely new or has been thoroughly revised from previous editions, and each is accompanied by tables listing all major nonprescription drug products within that specific group. The individual listings include brand names, manufacturers' names, and active and (in many cases) inactive ingredients. The product information was submitted by the manufacturers earlier in 1982.

Also new in this edition are a chapter discussing the Food and Drug Administration's continuing review of nonprescription drug products, written by the director of that review, William E. Gilbertson, and a chapter on patient assessment and consultation. In addition, the new edition includes a series of color plates which illustrate common dermatologic and dental/oral disease states which are described in the *Handbook*.

The *Handbook of Nonprescription Drugs* is available for $45.00 ($30.00 for APhA members) from the Order Desk, American Pharmaceutical Association, 2215 Constitution Ave., NW, Washington, DC 20037. Orders totaling less than $200.00 and all foreign orders must be prepaid in U. S. funds; foreign orders must also include $9.00 per copy to cover shipping and handling. To obtain APhA member rate, members must attach a mailing label from an APhA periodical to their order.

The American Pharmaceutical Association is the national professional society of pharmacists. Its membership includes practitioners in a variety of settings, pharmaceutical scientists, pharmacy educators, and pharmacy students.

* * *

Tom Sanders left, President of the TMA Foundation, presents a check for one thousand dollars to Al Mebane, Executive Director, NCPhA, for the TMA Foundation Fund, a part of the Consolidated Student Loan Fund. Loans from this and other funds are made available to undergraduate pharmacy students for living/school expenses. Smith photo.

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DEAN'S MESSAGE
"THE ACADEMIC PARTNERSHIP"

As your dean, and as I'm sure all dean's do, I once in a while reflect philosophically on the purpose of educational institutions. The message I wish to convey is nothing new, but a reiteration of a few basic concepts. Most important is the understanding by both students and faculty that the academic enterprise is a partnership, a contract if you will, between the institution and the students in which both must take an active part. Education is not a passive process—to absorb water like a sponge. As is true of many biological processes, education is also an active process. The institution's contractual commitment is to offer the optimal environment in which an education can be obtained—the student's responsibility is to actively absorb and assimilate the information for future retrieval and synthesis of ideas for the benefit of society.

In addition to the task of learning professional skills, the truly educated individual can communicate well, possess problem-solving abilities, discriminate right from wrong—fraud from fact. The logic of reason and objectivity, a sense of ethics and morality, must be ingrained in each student. For some years these have been deteriorating in our society, even at the highest levels. It is time that educational institutions begin to address these issues conscientiously. The professionalization process begins with the basics—appropriate attire, attendance, and general behavior. Your School has established a committee on *professionalism* to explore a variety of avenues targeted to instill into students these items which are the hallmarks of a truly educated person.

Your School is interested in you, the student, and your future as well as the future of pharmacy. So, let us jointly fulfill our educational contract.

Dean Tom S. Miya

Dr. Jack Wier presenting John McCall the check from the Fonnie Jackson Andrews Award.

STUDENT INDUSTRIAL INTERNSHIPS

This is the fourth consecutive year that our Pharmacy students have excelled in competition sponsored by the National Pharmaceutical Council. Now in its tenth year, the NPC program is intended primarily as a learning experience that will add to the participating students' overall knowledge of pharmacy, with emphasis on its industrial aspects.

Eight of our students were selected from fourth and fifth year pharmacy students nationwide to participate in summer internship programs with major pharmaceutical companies. We feel that having eight students participate is a distinction not only for the students, but also for the School, as applicants from forty-six schools applied for only eighty-seven positions.

The students and their respective affiliation were as follows:

Karol Krueger (Conover, N. C.)—A. H. Robins Company

Lynn Hobgood (Roxboro, N. C.)—Burroughs Wellcome Company

John McCall (Charlotte, N. C.)—Burroughs Wellcome Company

Susan Benolken (Elon College, N. C.)—Burroughs Wellcome Company

Cynthia Knapp (Totowa, N. J.)—Merrell Dow

Betsy Ash (Huntington, N. Y.)— Roche Laboratories

Elizabeth Kernodle (Burlington, N. C.)—E. R. Squibb and Sons

David Griffin (Burlington, N. C.)—The Upjohn Company

McCALL RECEIVES AWARD

On September 7, Dr. Jack K. Wier, Chairman of the School of Pharmacy's Scholarships and Awards Committee, presented John McCall, 5th year pharmacy student, a $1500 check from the Fonnie Jackson Andrews trust fund. The award was presented to Mr. McCall in recognition of his positive attitude towards and contributions to the profession of pharmacy.

Although this award was announced in the spring, Mr. Andrews requires that the check only be given upon the students' return in the fall semester.

FACULTY ATTEND ACCP and AACP MEETINGS

In June, several of the faculty from the School of Pharmacy attended meetings in Kansas City, Missouri. The Third Annual Meeting of the American College of Clinical Pharmacy was held June 25-27 and was attended by DR. RALPH RAASCH, Assistant Professor, and MR. HEYWARD HULL, Clinical Associate Professor in the Division of Pharmacy Practice.

The American Association of Colleges of Pharmacy held their meeting on June 27-30. Faculty who attended were DR. GEORGE COCOLAS, Associate Dean and Professor in the Division of Medicinal Chemistry, MRS. JUNE McDERMOTT, Clinical Instructor in the Division of Pharmacy Practice, DR. ABRAHAM HARTZEMA, Assistant Professor in the Division of Pharmacy Administration, DR. JEAN PAUL GAGNON, Professor and Chairman of the Division of Pharmacy Administration along with DR. RAASCH and MR. HULL. DR. RAASCH represented the School of Pharmacy as a Faculty delegate at the House of Delegates. DEAN COCOLAS served as an Administrative Delegate. He also reported on the American Journal of Pharmaceutical Education (of which he is editor), presented the Lyman Award Winner for best publication of the AJPE, and attended the Board of Director's meeting and Teacher's Seminar. DR. GAGNON met with the Board of Directors representing the Council of Faculties. MRS. McDERMOTT presented a paper on AHEC in North Carolina. DR. HARTZEMA presented two papers: "Comparison of Terminal and Professional Values of Pharmacy Students with Four Reference Groups" and "Differential Emphasis in Social Pharmacy Programs: A Cross-National Analysis of Historical Development." MR. HULL presented two papers entitled "An Educational-Training Program in Clinical Research and Drug Development for the Clinical Pharmacist" and "SAS-NLIN, A Simple but Effective Alternative to NONLIN".

Why can't life big problems come when we are young and know everything?

PROFESSIONAL TASK FORCE

Professionalization of pharmacy is a dynamic process. The many advancements in science, technology and health care systems which are occurring require continuous analysis and revision of the philosophy and content of pharmaceutical education. A task force has been appointed to address the issue of student professional attitude and respect for the profession of pharmacy. Celeste Lindley of the Division of Pharmacy Practice and Orange Chatham Comprehensive Health Services is chairing the Task Force. Throughout the year, the group will be addressing the following recommendations:

1. Students need early practical experience in progressive pharmacy practice sites in order to more clearly visualize their future roles in pharmacy and to optimize the application of their didactic training.

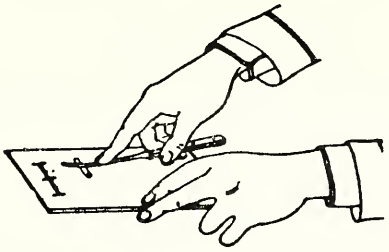
2. Students should be made aware of their career options within the profession of pharmacy and should be exposed to the issues relating to the current status and changing practice of pharmacy.

3. Students' ability to communicate verbally and in writing, and to apply principles from didactic training to the practice setting must be improved.

4. An Honors Program should be designed and implemented for the purposes of (1) meeting the needs of the highly motivated pharmacy students, (2) providing role-model students for other students to emulate, (3) serving as a recruitment tool at both the undergraduate and graduate levels.

5. All faculty members at the School of Pharmacy should serve as role models for the pharmacist of the future.

6. Efforts should be made to improve communication between educators and practitioners in every field of pharmacy.



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DRUG INFORMATION REPORTS

John Kessler, Pharm.D.
Drug Information Center
North Carolina Memorial Hospital

How does one prepare DDAVP (desmopressin) for pediatric patients? Desmopressin (DDAVP) is used to treat the symptoms of diabetes insipidus. It is administered through a flexible, calibrated tube that the patient fills with the correct dose. One end of the tube is inserted into the nose, and the patient blows sharply into the opposite end of the tube to propel the solution deep into the nasal cavity. When self-administration of the solution is not possible, a partner may use an air-filled syringe to propel the solution from the tube. (Detailed pictorial instruction for the patient accompany each bottle.)

Frequently at North Carolina Memorial Hospital, doses of DDAVP less that 0.05 ml (the smallest calibration) are required for pediatric patients. In these cases the Pharmacy Department prepares the following product according to the recommendations of Ferring Pharmaceuticals:

DDAVP 0.01%	2.5 ml
Normal Saline q.s.	10.0 ml

The dilution is prepared aseptically in the original DDAVP bottle and results in a final concentration of 0.0025%. Therefore, patients who required 0.025 ml of the original strength DDAVP, can now be treated with 0.1 ml of the diluted product, a measurable quantity.

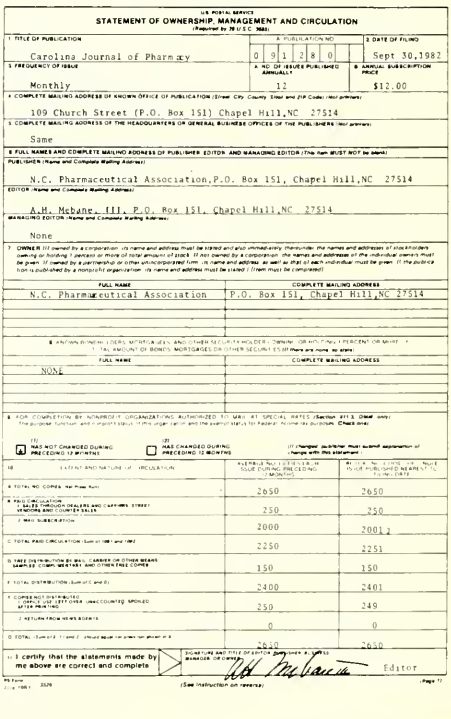
Normal saline for injection *without a bacteriostatic agent* is the preferred diluent and, when refrigerated, is stable for 2-3 months. Each bottle should then be relabeled with the correct concentration and expiration date.

PUBLICATIONS

DR. J. HERBERT PATTERSON, Assistant Professor in the Division of Pharmacy Practice had a book review published in the Fall 1982 issue of the *American Journal of Pharmaceutical Education* 46: 318. He reviewed the book by P. F. D'Arcy and J. P. Griffin entitled *Iatrogenic Diseases, Second Edition, Update 1981.*

DR. LARRY J. LOEFFLER, Professor in the Division of Medicinal Chemistry, and DR. MARK HOLSHOUSER, former graduate student in the School of Pharmacy, published an article "Synthesis and Antitumor Testing of 3-Methenylthiochroman-4-one-1,1-dioxide" in the June 1982 issue of *Pharmaceutical Sciences* 71: 714-16. DR. LOEFFLER and DR. HOLSHOUSER joined DR. IRIS HALL, Associate Professor in the Division of Medicinal Chemistry, in publishing "Effects of 3-Chloromethylthiochromone-1, 1-dioxide on Nucleic Acid, Protein, and Aerobic and Anaerobic Metabolism of Ehrlich Ascites Tumor Cells" in the August 1982 issue of *Journal of Pharmaceutical Sciences* 71: 857-61.

DEAN TOM MIYA chaired the Task Force of Toxicology Past Presidents which recently published an article on "Animal Data in Hazard Evaluation: Paths and Pitfalls" in *Fundamentals of Applied Toxicology* 2: 101-107 (1982).



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THE BODY IN QUESTION

Jonathan Miller, the renowned performer, theatre-opera-television director, and physician, will again be seen with his acclaimed forays into the workings of the human body when his thirteen-week THE BODY IN QUESTION began at 9:00 PM, ET, on Saturday, October 16 on the Public Broadcasting Service (PBS).

As with the first PBS showing, the thirteen weekly hours of THE BODY IN QUESTION is made possible on Public Television by a grant from Hoffmann-La Roche Inc., a leading health care company headquartered in Nutley, New Jersey.

In THE BODY IN QUESTION, Dr. Miller, with the wit, charm and intellectual zest for which he has become known the world over, recreates early scientific experiments, performs what may very well be the first postmortem to be filmed for television, subjects his own body to a variety of tests, and uses special effects, art, architecture, historical recreations, literature, and experiments to help clarify complex medical knowledge.

Dr. Miller theorizes that while advances in modern medicine are the result of heroic procedures and miracle drugs, they also came about from new knowledge of what a healthy body is and how it protects itself and survives.

Dr. Miller points out that the gradual understanding of how the body works often runs parallel to mechanical inventions. One example he gives is that it was not until the seventeenth century that the British physician and anatomist William Harvey (1578-1657) saw a fire pump in action and later developed the theory that the heart worked on the same principle to circulate the blood. Other examples Dr. Miller brings up are the impact of World War II artillery and computer technology on the understanding of muscular development and brain function.

Throughout the series, Dr. Miller traces advances in medical knowledge from the beginning of the Renaissance to the present and shows how these developments are related to events in politics and trends in culture as well as to industry, craftsmanship, and engineering.

Elections Committee members Lloyd Senter, Loni Garcia and Bob Smith are shown tallying ballots for NCPhA offices. Staff photo.

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As you may be aware, many employers, both chain and independent, will reimburse you for up to one-half your annual dues in the NCPhA. You must request this, however, and a receipt is often required. If you need such a receipt, please complete the form printed below and return to the

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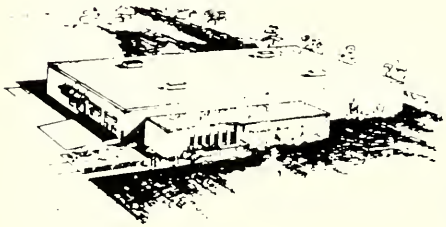

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BIRTHS AND DEATHS

Rebecca and David Work, Chapel Hill, are happy to announce the birth of their daughter Susan Margrethe. She was born at Durham County General Hospital on October 14, 1982 and weighed in at 6 pounds and 2 ounces.

Patty and Robert Giddings, Chapel Hill are happy to announce the birth of their son Robert Clayton, September 15 at Durham County General Hospital. He weighed eight pounds and thirteen ounces. The Giddings also have a daughter Kristina, who is two years old.

CARLTON O. WINTER

Carl O. Winter, Jacksonville, died May 31, 1982 at the age of 79. He was a graduate of the South Carolina Medical College and a member of the South Carolina Pharmaceutical Association and the North Carolina Pharmaceutical Association. He received his 50+ certificate from the NCPhA at the Annual Convention in Charlotte in 1981.

JOSEPH C. ESTES, JR.

Joe Estes, Reidsville, died Saturday, August 21, 1982 at Annie Penn Hospital in Reidsville. He was 60 years old. He was the President of the Rockingham County Pharmaceutical Association and a life member of the North Carolina Society of Hospital Pharmacists. He was a graduate of the UNC School of Pharmacy and was associated with Annie Penn Hospital until he retired.

PHILIP DAVID BRAUER

Philip D. (Phil) Brauer, Lexington, died at his home Sunday, May 23, 1982. He was 34 years old. A native of Andrews, in Graham County, he attended the University of North Carolina and was a 1971 graduate of the Mercer School of Pharmacy in Atlanta.

LISA KING GRACE

Lisa King Grace, Raleigh, was killed in an automobile accident Wednesday morning, September 29, 1982, when her car was struck by a pick-up truck. She was 28 years old and a pharmacist-manager for Kerr Drug Company in Raleigh. A native of Bristol, Grace was a 1977 graduate of the University of South Carolina College of Pharmacy.

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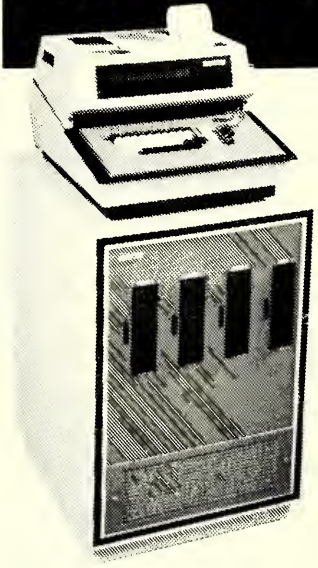

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OCTOBER 1982

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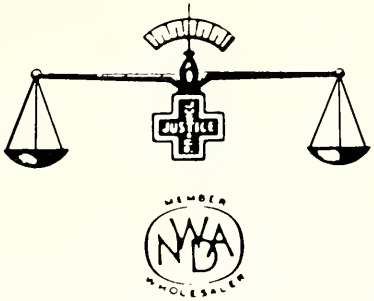

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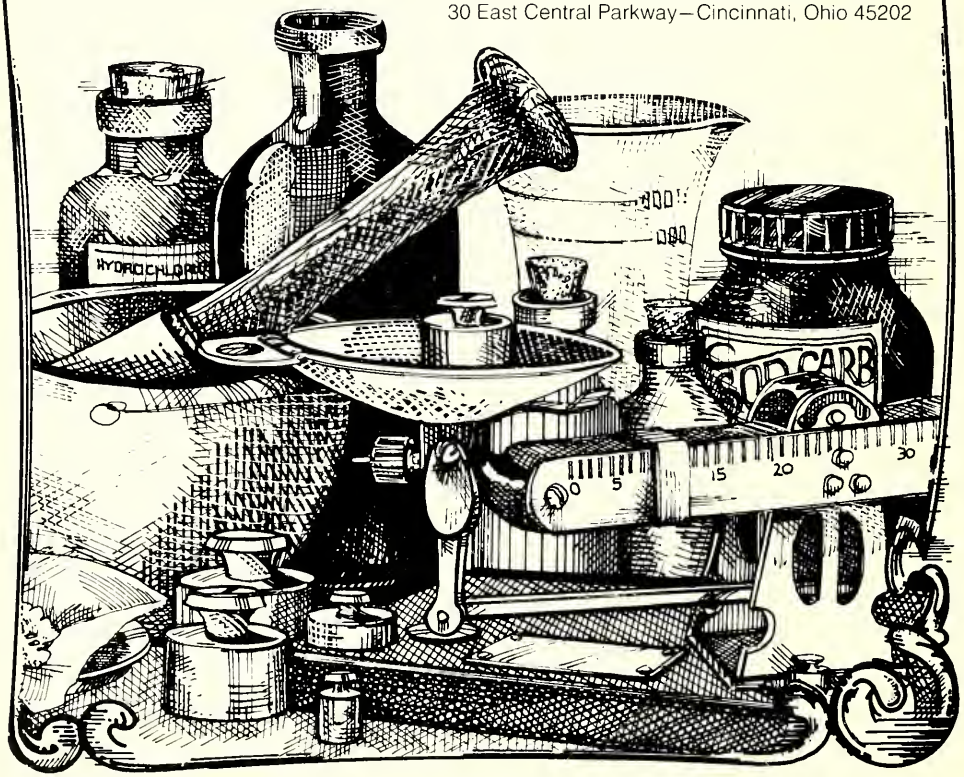

THE CAROLINA JOURNAL of PHARMACY

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OCTOBER 1982 VOLUME 62 NUMBER 10

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October, 1982

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MAINTAINING FINANCIAL STRENGTH*

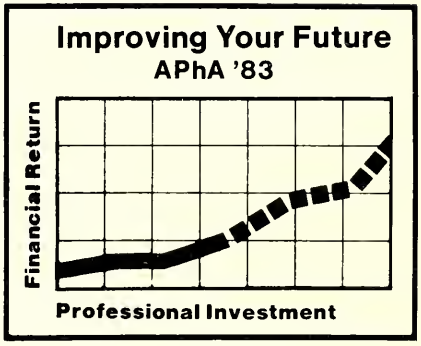
The current recession has lasted so long and cut so deeply that virtually every major sector of the economy, region of the country, and type of worker has been affected. The slump—made worse by cutbacks in Medicaid spending—has hurt community pharmacies in every part of the country. Even large chain pharmacies have felt the pinch as consumer spending has softened.

Few pharmacies have well thought out financial survival plans for bad times. When trouble develops, indecision and seat-of-the-pants management prevail. As a result, too little is often done too late! Unprepared companies fail to realize the trouble they are in until a major crisis develops. Others plunge ahead on the vague assumption that things will somehow get better on their own. Tentative leadership and unfounded optimism often prove disastrous, even when a pharmacy appers to be financially healthy.

Pharmacies that survive the current recession will be those that are lucky or implement decisive actions to preserve their financial strength. Maintaining a strong financial base is the key challenge facing today's pharmacy manager. Meeting that challenge requires serious attention, tough choices, and decisive action. Those who meet the test will be poised to take full advantage of the eventual recovery.

Many factors affect how well a pharmacy does financially, and today's manager can afford to ignore none of them. But three of them demand constant vigil: *reducing costs, controlling inventory,* and *improving cash flow.*

Below are dozens of ways other pharmacies are facing the need to manage boldly and aggressively. Some may not apply to you. On the other hand, do not dismiss any of them without some forethought. Each idea provides some help; used together they can provide very powerful help to maintain a pharmacy's financial strength.



130th Annual Meeting
American Pharmaceutical Association
April 9-14, 1983
New Orleans, Louisiana

Reducing Costs

- Provide incentives to employees for ideas to reduce costs.
- Promote from within rather than hire from outside to save money and improve staff morale.
- Develop a list of "idle time" tasks that will make better use of existing personnel.
- Conduct inhouse training to improve employee skills. Focus on ways employees can help reduce costs and cross-training.
- Consider sub-leasing pharmacy space that is not producing adequately to a related operator.
- Ask the local utility to conduct an energy audit to reduce energy consumption.
- Defer making computer software and hardware changes unless they pay off quickly with reduced costs.
- Monitor mailing practices for opportunities to save money. Check into second and third class.
- Use white envelopes for all classes of mail; postal workers tend to handle them as first class anyway.
- Determine whether long-distance costs can be reduced by using alternate service suppliers.
- Increase security measures aimed at both internal and external theft.

* By Bruce R. Siecker, Ph.D., *Director, APhA Pharmacy Management Institute,* 2215 Constitution Avenue, NW, Washington, DC 20037.

• Review advertising practices with a view of highest efficiency in reaching the desired audience.

• Determine whether new equipment, which is absolutely essential, can be leased attractively to avoid major capital outlays.

• Examine payroll costs and wage rates in lieu of local conditions; consider the possibility of layoffs, reduction in wage or salary, and even permanent reductions in staff.

• Ask employees to suggest activities that can be combined or eliminated. Pay particular attention to similar and overlapping activities completed by different employees.

• Meet with key employees to get their ideas and commitments to reduce costs.

• Review insurance costs, looking for coverage that can be consolidated or reduced.

• Increase insurance deductibles to reduce premiums.

• Assign someone to look critically at the ways prescriptions are processed with the aim of reducing wasted motion and activities.

• Use high-school students for housekeeping rather than more expensive staff or a janitorial service.

• Review salary policy. Overtime merit raises and bonuses tend to become automatic.

• Eliminate unnecessary local and out-of-town travel.

• For necessary travel, investigate budget motels and Super Saver rates. Use public or low-cost limo transportation services when out of town.

• Study the amount of staff time dialing the thirty most-frequently called numbers. The monthly cost of an automatic dialing device maz be less.

• Get rid of all paperwork that is not essential, especially internal reports that no one reads and forms that are rarely used.

• Monitor hourly sales activity to determine whether pharmacy hours should be adjusted or staff rescheduled in response to changing sales patterns.

• Form a buying group to negotiate better terms from local suppliers.

• Decide whether you are getting your money's worth from the pharmacy's accountant, banker, legal and financial advisors.

• Talk with other pharmacy managers, and managers of related firms, to see how they are reducing costs.

Controlling Inventory

• Eliminate low-margin, slow-turnover items and lines, e.g., items with turnovers of less than three and margins of less than 30%.

• Investigate suppliers that offer consignment terms.

• Limit promotional buying to those items normally carried in stock.

• Establish a maximum time any item can be in stock before it is returned, sacrificed, or discarded, e.g., 180 days.

• Hesitate to add new lines.

• Adopt demand purchasing where the demand for the item and a target turnover determine how much is stocked.

• Reconsider direct purchase habits for their impact on increasing inventory levels because of high minimums.

• Think more about the carrying cost of inventory; carrying costs far exceed ordering costs in community pharmacies.

• Consolidate purchasing with one wholesaler in exchange for better terms and services.

• Study which lines respond best to price level; consider discounting leading items in those lines to improve inventory turnover and strengthen price image.

• Make sure the count is accurate. Check all incoming orders to be sure there are no shortages.

• Some suppliers attempt to improve their own cash flow by delivering early. Institute a "start ship" practice, especially for seasonal goods, to show the first date delivery will be accepted.

• Terminate all automatic shipment arrangements for new items.

• Stop buying every promotional deal that is offered. Deals increase inventory unnecessarily and produce a false sense of prosperity.

• Institute a program of regular physical counts. Identify high cost items, then assign someone specific responsibility to keep quantities at bare minimum.

Improving Cash Flow

• Establish a payment calendar so invoices are not paid too soon.

• Begin adding a service charge on inactive and overdue receivable accounts.

(Continued on Page 7)

Group Life And Health Insurance Benefits For Members Of

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Pilot Life Insurance Company is pleased to have been selected as the Group insurance carrier for the North Carolina Pharmaceutical Association. It would be to your advantage to become thoroughly acquainted with the benefits of this program.

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Telephone 919/723-8811

Pilot Life

(continued from page 5)

- Divide receivable accounts into two groups; bill one group every two weeks to smooth cash in-flow.
- Prepare accounts in descending dollar amounts, rather than in alphabetical or account number order.
- Mail account statements as they are completed, not waiting until they are all done.
- Use first-class postage on high-dollar accounts receivable to speed delivery.
- Establish a faster schedule for submitting third-party claims.
- Teach staff how to sell larger sizes and make companion sales, thereby increasing average sales per transaction.
- Eliminate all nonessential or low-value staff activities so they can focus more attention on customer service.
- Offer a discount for those who pay with cash.
- Have a sidewalk sale to clear out old stock, then do not restock.
- Consider offering a discount on the purchase of the second package of a given item.
- Defer nonessential capital investments.
- Partially or wholly replace cash bonuses and awards with gifts of inventory or offer employee discounts on purchases in lieu of cash awards.
- Ask your accountant whether depreciation schedules can be accelerated.
- Examine records to see whether tax deductions were missed.
- Be sure to take an investment tax credit on capital purchases. It may also be possible to get an investment tax credit on leased equipment if the lesser failed to take one.
- Take a very hard, long look at the benefits and costs of current delivery practices. Think about other ways, a reduced service level, or even elimination of delivery.
- Begin levying a delivery charge.
- Increase the charge for bad checks. Some banks are now charging $10-15 per bounced check.
- As the inventory level is reduced, adjust insurance coverage downward.
- Pay *all* bills by check; make deposits in person.
- Attempt to negotiate special, longer payment terms.

Charles Woodard, left, President of the Northeastern Carolina Pharmaceutical Association, presents a check to NCPhA President Ernest Rabil, establishing the W. Thomas Boone Loan Fund, in honor of 1982 Pharmacist-of-the-Year Tom Boone, at the Mortar and Pestle Dinner held in Ahoskie. Photo by Colorcraft

- Watch the age of receivables closely. Establish standard procedures and specific actions when account is 30, 60, and 90 days overdue.

PHARMACISTS IN THE UNITED STATES

According to the latest statistics released by the National Association of Boards of Pharmacy, there were 156,958 pharmacists licensed in 1981. From national averages computed by NABP, the following statistics are available:

- 74.11% or approximately 116,265 of all active pharmacists are involved in community practice.
- 18.52% or approximately 29,053 of all active pharmacists are practicing in hospital pharmacies.
- 1.36% or approximately 2,133 of all active pharmacists are involved in manufacturing or wholesale.

(continued on page 9)

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DOE, JOHN A. 08/04/82
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℞ LABEL
SUMYCIN 250 MG 40 CAP
01 REF C A BELCHER

A/R AUDIT

DOE, JA - CAB 08/04/82
DOE, JOHN A.
6001052 AMOUNT 4.32

AA1131123
ALLEN, GEORGE 40 CAP 0101
SUMYCIN 250 MG
-A- 00003-006551

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DOE, JOHN A 08/04/82
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- JULY 1-5 19

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(continued from page 7)

- 3.04% or approximately 4,769 of all active pharmacists are practicing in teaching or government settings.
- 3.02% or approximately 4,738 pharmacists are practicing in other pharmacy capacities.
- 20.53% or approximately 32,207 of all active pharmacists are female.

QS/1 PHARMACY SYSTEMS INSTALLS 500TH SYSTEM

QS/1 Pharmacy Systems, the South Carolina based manufacturer of pharmacy computer systems, has recently sold its 500th system, Smith Data Processing president Glenn Hammett has announced.

The landmark installation is at the Towne and Country Pharmacy in Ridgewood, New Jersey.

Hammett said, "We are obviously delighted that we've reached this goal in such a short period of time. We owe a debt of gratitude to our network of distributors and to the staff here in the corporate office for their efforts over the past five years that brought us to our 500th installation."

The system was sold by the Professionals' Data Services Center, Inc. (Pro Data) of East Longmeadow, Massachusetts, one of the oldest and highly respected distributors of QS/1. Pro Data is the QS/1 distributor for all of New England, New Jersey and portions of New York state and is solely responsible for placing 57 QS/1 pharmacy systems since their introduction to the marketplace.

Distributed and serviced nationally through a network of local distributors, QS/1 systems are operating in 44 states and several provinces of Canada. According to Hammett, each day the systems process an average of 85,000 prescriptions and maintain records for over 2.6 million patients.

QS/1 Pharmacy Systems is designed and manufactured by Smith Data Processing (SDP). Its parent, the J M Smith Corporation, has been serving pharmacists for over 40 years through its other division, Smith Drug Company. Founded in 1959 as a general data processing service, SDP began distributing the pharmacy system in 1977 and has grown rapidly into one of the largest suppliers of computer systems for pharmacists in America.

The system utilizes the IBM Series/1 computer and carries a comprehensive software package that handles everything from prescription processing to accounts receivable and third party claims.

Smith Data Processing is headquartered in Spartanburg, South Carolina. The QS/1 family of distributors along with SDP form a close-knit working group named United Distributors of America with Ken Hill, R.Ph. of Granbury, Texas as its president.

Commemorating the landmark installation of the 500th QS/1 Pharmacy System at the Town and Country Pharmacy are Jerry Bland, IBM; Glenn Hammett, Smith Data Processing president; Louie Phipps, SDP; Robert Zadra, Town and Country pharmacist; Paul Emanuel, Town and Country owner; Russ Weber, Pro Data; and C. W. Bartley, President of Pro Data.

ANNUAL MEETING N. C. TRIPARTITE COMMITTEE ON PHARMACY

The Annual Meeting of the North Carolina Tripartite Committee on Pharmacy was held Monday night, September 20, 1982. Present were members W. R. Adams, W. H. Randalls, Jr., Marion M. Edmonds, Joe A. Edwards, Steve M. Caiola, George H. Cocolas and Claude U. Paoloni. Also present were Ex-Officio members A. H. Mebane, III, and Tom S. Miya, as well as guests Chris Dixon—president, SAPhA, Mary Dorsey—president, Student Body, School of Pharmacy, Sheila Whitehead—President, SNPhA, David D. Claytor and Ralph Raasch. Chairman Edmonds convened the meeting at 7:00 p.m. in the Board Room of the Institute of Pharmacy and welcomed the students and guests in attendance. Having declared a quorum, the minutes of the September 14, 1981 meeting were approved as distributed.

I. Review of the Academic Externship Program

Mr. Paoloni reviewed the activities of the Academic Externship Program of the Fall, 1981, and Spring, 1982 semesters as well as the summer Modified Academic Externship Program conducted for the 4/5 students who were admitted into the Pharm.D. tract. (Copies of the data presented are attached to the Secretary's minutes.) Student's attitudes reflect a high degree of positive participation, this is also supported to a fairly high degree by the practitioner-instructor activities, including the PI Recognition Dinner Meetings of the AHEC's at which time "Certficates of Appreciation" were presented to the PI's.

Also, discussion concerning the possibility of implementing some introductory-type of experimental training for pharmacy students who have completed their first professional (3/5) year took place. No concensus was reached even though there seemed to be strong support for a post-3/5 introductory experimental training program.

II. Review of the School's Pharm.D. Program

Dr. Ralph Raasch reviewed the status of the Pharm.D. Program. Six students were admitted this past year; 2 tracted from the 4/5 year. In all, 11 students continue in the program, 5 are presently in their second year devoting practically all of their time to clerkships. The A.C.P.E. provisionally accredited the program for optional tract students on the basis that no more than seven students per year would be admitted. It is also important to note that the Pharm. D. program is "approved" but "not funded." It is expected funding will not be provided until the 1985-86 budget year. Ralph reported the program is running smoothly; modifications have been made to improve and strengthen the programs and we expect further refinement as more experience is gained.

III. School's Enrollment

Dr. George Cocolas reviewed the admissions, enrollment and recruitment efforts of the School. Enrollment for the School seems to have leveled off with a small decline forecast for the future years. The School admitted 170 students in the 3/5 class of which 167 enrolled. Projections show that in order to maintain the proper full time equivalents of students, the beginning (3/5) class in future years will be 160. Factors such as the size of the PharmD. program, the graduate program, the number of students attending Summer School, and the full time equivalents obtained from continuing education programs impact on the size of the undergraduate B.S. program

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size. The school graduated 160 students last year (1982) and will likely repeat that number in 1983.

Recruitment efforts for undergraduate students are a continuing activity of the School. An Open House is planned for Saturday, October 2nd. Recruitment through high school counselors is a long term commitment and is presently being more fully developed through contacts at the local level by pharmacists and students located near those high schools. (Explicit data presented are attached to the Secretary's minutes).

IV. The Revised Pharmacy Practice Act

Bill Randall reported the Revised Pharmacy Practice Act became effective July 1, 1982. The Board is currently working on promulgating rules and regulations to coincide with the new law. Hopefully, the first public hearing on Part I of the regulations will be held in the latter part of November. Bill Adams stressed the importance of having maximum impact from the pharmacists throughout the state during the public hearings. Discussion also prevailed on the subject of continuing education. The Board may require licensees to obtain up to 10 hours of continuing education from board approved programs as a condition of license renewal.

V. 1983 NABP/AACP District III Meeting

Mr. Paoloni reported that next year, The North Carolina Board and the School will be hosting the District III NABP/AACP District Meeting at the Blockade Runner, Wrightsville Beach, on August 14, 15, and 16, 1983. We should begin developing the program now which, hopefully, will be completed by the end of November 1982.

VI. Election of Officers

Nominated were:

Chairman, Steve Caiola—1982-83

Vice-Chairman, William Adams—1982-83

Secretary, Claude U. Paoloni—1982-84

Candidates were elected by acclamation and duly installed.

VII. New Business

The subject of continuing education and the apparent need to assure competency in our profession continued to be discussed. The newly elected Chairman, Steve Caiola, felt this is a matter of much importance. A meeting prior to the next annual meeting may be called to discuss this specific issue.

VIII. Adjournment

Before adjourning at 9:10 p.m. Al Mebane complimented the members and the students for their attendance and participation in the deliberations of the meeting.

POISON PREVENTION MATERIAL

The Duke Poison Control Center is offering a supply of the poison prevention pamphlet, "Poison at Work," to pharmacists willing to distribute them. In addition, a 10-minute slide/tape presentation is also available for a two week loan period, at no charge. To obtain the pamphlets, send a self-addressed stamped business envelope to:

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PHARMACY CALENDAR ITEMS

ASHP Midyear Meeting
Los Angeles—December 5 through 9, 1982

NC Board of Pharmacy Examinations
Chapel Hill—January 24, 25, 26, 1983

SocioEconomic Seminar
Chapel Hill—February 16, 1983

NARD Legislative Conference
Washington, DC—March 15, 16, 17, 1983

Poison Prevention Week
March 20 through 26, 1983

APHA Annual Meeting
New Orleans—April 9 through 14, 1983

NCPhA Annual Convention
Boone—June 19, 20, 21, 1983

NARD Annual Meeting
Las Vegas—Sept. 19 through 23, 1983

Our best friends are our severest critics and our greatest assets.

Meet our 1982 Pharmacy Consultant Panel.

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Community Pharmacist
Louisville, Kentucky

Louis M. Sesti, R.Ph.
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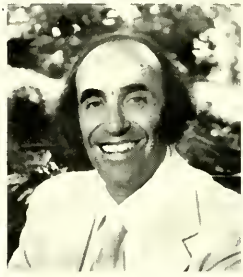

Harold H. Wolf, Ph.D., R.Ph.
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University of Utah
Salt Lake City, Utah

Paul Burkhart, R.Ph.
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University of Maryland Hospital
Baltimore, Maryland

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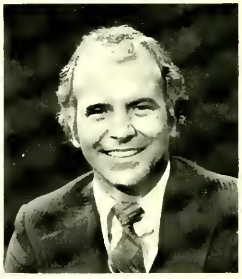

Lawrence A. Diaz, R.Ph.
Community Pharmacist
Gainesville, Florida

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Their views on professional and other pertinent matters are invaluable.

Their advice and counsel helps us serve you better in the expanding role of pharmacy.

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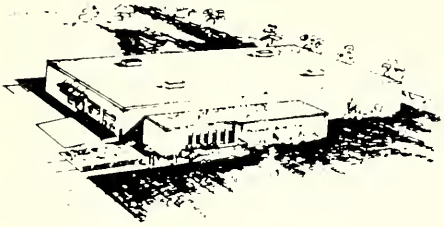

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NORTH CAROLINA SOCIETY OF HOSPITAL PHARMACISTS

ACUTE OTITIS MEDIA

Pamela U. Joyner, M.S.
Pharmacy Coordinator
Wake Area Health Education Center
Clinical Assistant Professor
University of North Carolina
School of Pharmacy

Otitis media, first described by the Greek physician, Hippocrates,[1] is an infection of the middle ear that is often preceded by an upper respiratory tract infection. It is one of the most common infectious diseases of childhood.[2,3] One study of 488 pediatric patients found that 67 percent had developed at least one episode of otitis media by two years of age.[4]

The high incidence of otitis media is significant because it can diminish hearing and cause learning disabilities. This is a special problem for the child under four years of age, the critical period of speech and language development.[5,6]

Epidemiology and Pathogenesis

Infants and young children between six and 36 months are at highest risk for developing otitis media.[7] The incidence is higher in males, lower socioeconomic groups, Eskimos, American Indians, and in children with cleft palate or other craniofacial anomalies such as those seen in Down's syndrome. The incidence of otitis media is also higher during winter and early spring.[8]

The increased susceptibility of otitis media in young children is due, in part, to incompletely developed eustachian tubes. In infants, the eustachian tube is shorter, wider, and more horizontal than that of the older child. This anatomical immaturity enables organisms from the nasopharnyx to enter the middle ear more easily than they do in the older child and adult.[9]

Etiology

The microbiology of acute otitis media has been identified by cultures of middle ear fluid obtained by needle aspiration. *Streptococcus pneumoniae* (pneumococcus) and *Hemophilus influenzae* have been found to be the most prevalent organisms in all age groups.[10] The *pneumococcus* accounts for approximately 30 percent of all otitis media infections. *Hemophilus influenzae* is responsible for 25 to 30 percent of infections.[11] Until recently, *Hemophilus influenzae* was not considered a significant cause of otitis media in children over five years of age. However, studies show an increased incidence of this organism in older children and adults.[12,13] Howie et al[12] found that *H. influenzae* caused 19 percent of otitis media cases in children older than five years of age. Schwartz et al[13] studied 58 children with otitis media between the ages of five and nine years. *Hemophilus* was found to be the primary pathogen in 36 percent of the cases. Less common causes of acute otitis media include group A beta-hemolytic *streptococcus, Neisseria catarrhalis, Staphyloccus aureus,* and various gram-negative bacilli including *Escherichia coli, Klebsiella pneumoniae, Pseudomonas aeruginosa,* and various *Proteus* species.[10] In neonates, about 20 percent of the isolates from middle ear fluid contain gram-negative enteric bacilli.[14]

As many as 25 percent of the cultures of middle ear fluid are negative.[10] Epidemiologic data suggest that virus infection is associated with acute otitis media, but viruses are rarely recovered from cultures of middle ear fluid. Although Henderson and associates[15] did not isolate viruses directly from middle ear fluid, their research, during a 14-year study of respiratory infection in young children, found that the incidence of otitis media was higher in children with viral respiratory infections

(Continued next Page)

ACUTE OTITIS MEDIA

caused by respiratory syncytial virus, adenovirus, and influenza virus.

Diagnosis

Ear pain and fever suggest infection of the middle ear, but many children with otitis media do not have these signs. Symptoms in infants include irritability or difficulty with feeding or sleeping. Children too young to talk may rub their ears or give no sign at all. Because there is such a wide range of symptoms in infants and children, the tympanic membrane should be examined carefully to confirm the diagnosis.[16]

In general, it is not necessary to make a bacteriologic diagnosis of acute otitis media since the results of microbiologic studies of acute otitis media provide a guide to the most likely pathogens. Tympanocentesis (needle aspiration of middle ear fluid) provides specific information about the bacteriology of the infection and should be considered in selected patients. Some indications for tympanocentesis include: (1) otitis media in seriously ill children; (2) otitis media that persists after antimicrobial therapy; (3) otitis media developing in a child already receiving an antibiotic; (4) neonatal otitis media; (5) otitis media in the compromised patient; and (6) otitis media accompanied by suppurative complications, such as mastoiditis and meningitis.[7,10]

Drug Therapy

Since there have been fewer reported complications from otitis media since the introduction of antibiotics, there is almost universal agreement that infants and children with otitis media should receive appropriate antimicrobial therapy. An antibiotic regimen for acute otitis media should provide adequate coverage against the two most frequent pathogens, *S. pneumoniae* and *H. influenzae*.[17,18] *S. pneumoniae* is susceptible to penicillins, cephalosporins, erythromycin, and trimethoprim-sulfamethoxazole.[19] *H. influenzae* is sensitive to ampicillin, amoxicillin, and sulfonamides, but is less sensitive to penicillin and erythromycin.[11]

Traditionally, ampicillin or amoxicillin have been the drugs of choice in treating acute otitis media. These antibiotics are generally effective against *S. pneumoniae* and *H. influenzae*. Amoxicillin is usually preferred because it is more completely absorbed, less likely to cause diarrhea, and requires fewer doses per day.[11]

Recently, there has been an increasing number of *H. influenzae* strains that produce a beta-lactamase and are therefore resistant to ampicillin and amoxicillin.[20,21] Resistance rates vary with geographic location.[22] A survey of 45 of the largest pediatric medical centers in the United States in 1976-1977 showed the overall prevalence of ampicillin-resistant strains of *H. influenzae* to be five percent.[23] The latest resistance rates reported by the Center for Disease Control placed the overall national rate of ampicillin-resistant strains of *H. influenzae* at 18 percent in 1978,[24] but resistance rates as high as 35 to 40 percent have been reported in some areas of the United States.[25] The overall incidence of resistant strains with otitis media is low, but patients should be monitored closely in areas where resistance has been reported. If there is no improvement in 24 to 48 hours, the patient should be re-evaluated and, if necessary, the

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antibiotic regimen changed.[9] Combinations of penicillin and a sulfonamide, erythromycin plus sulfonamide, trimethoprim-sulfamethoxazole, and cefaclor are effective against ampicillin-resistant *H. influenzae*. Penicillin and erythromycin are effective alternatives against *S. pneumoniae,* but in order to have a regimen that is effective against *H. influenzae* as well, a sulfonamide is added.[11]

All patients should be re-evaluated after 10 to 14 days of antibiotic therapy to ensure that the infection has cleared. The examination also will determine whether any fluid remains in the ear.[9]

Additional supportive therapy including analgesics and antipyretics may be helpful. Antihistamines and decongestants have not been proven effective in the treatment of acute otitis media.[26]

Summary

Acute otitis media is one of the most common diseases of childhood. *S. pneumoniae* and *H. influenzae* account for 55 to 60 percent of cases. Amoxicillin is usually effective against both of these organisms and is the drug of choice. For ampicillin-resistant *H. influenzae,* effective alternative drug regimens include combinations of penicillin and a sulfonamide, erythromycin plus sulfonamide, trimethoprim-sulfamethoxazole, and cefaclor. The role of antihistamines and decongestants in the treatment of acute otitis media has not been established.

Antibiotics Used in the Treatment of Acute Otitis Media

Drug	*Dosage*	*Comments*
Ampicillin	50-100mg/kg/24 hrs. divided into 4 doses for 10 to 14 days	Generally replaced by amoxicillin in the treatment of otitis media.
Amoxicillin	20-40mg/kg/24 hrs. divided into 3 doses for 10 to 14 days	Diarrhea is less frequent following amoxicillin than ampicillin.
Penicillin V	50 mg/kg/24 hrs. divided into 4 doses for 10 to 14 days	Must be given with sulfonamide in order to provide adequate coverage against *H. influenzae.*
Erythromycin	50mg/kg/24 hrs divided into 4 doses for 10 to 14 days	Must be combined with sulfonamide in order to provide adequate coverage against *H. influenzae.*
Sulfisoxazole	150mg/kg/24 hrs. divided into 4 doses for 10 to 14 days	Must be given with penicillin or erythromycin in order to provide coverage against *S. pneumoniae.*
Trimethoprim-sulfamethoxazole	8mg TMP + 40mgSMX/kg/24 hrs. divided into 2 doses for 10 days	Alternative for penicillin allergic patients and otitis media caused by ampicillin-resistant *H. influenzae.*
Cefaclor	40-60mg/kg/24 hrs. divided into 3 doses for 10 to 14 days	(1) Alternative for otitis media caused by ampicillin-resistant *H. influenzae;* (2) May be used in penicillin allergic patients (5-10% cross-reactivity with penicillin); (3) Has been reported to cause serum sickness action in infants and children.

Note: references available on request from the author.

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Warren E. Taylor, FHFMA
Assistant Administrator
Memorial Hospital of
Alamance County
Burlington, North Carolina 27215
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Please call if you have any questions or any other needs which an NCHFMA member might address.

Sincerely,
Warren E. Taylor,
FHFMA President

To: The NCPhA
RE: NDC NUMBER CHANGES

Merrell Dow Pharmaceuticals Inc. became our new company name in March, 1981. Since that time you have been buying your pharmaceutical products from this company. Until now, Merrell and former Dow products had been manufactured at different sites under two separate NDC numbers.

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Sincerely,
Charles D. Combs
Director Trade and Professional Relations

TO: Pharmacy Organizations
FROM: Jefferson County Pharmaceutical Association

Dear Colleagues:

As you know the Jefferson County Pharmaceutical Association is engaged in a costly law suit and the decision reached may well effect the entire economic future of community pharmacy including independent practitioners as well as chain pharmacy practitioners.

Recently the NARD which is supporting our court case: "Jefferson County Pharmaceutical Association vs Abbott et al" has stated if the U. S. Supreme Court does not outlaw a Robinson-Patman exemption in our pending case involving government hospital prescription sales in the private sector then Congress should consider legislation against state hospital pharmacy drug purchasing advantages.

The NACDS at their recent convention also expressed great alarm concerning the increasing number of hospital pharmacies which are filling prescriptions for ambulatory (outpatients). Except for the ASHP which is advocating an explanation of hospitals role in filling out-patient prescriptions, most national pharmacy organizations are supporting us in this important case. The APHA has also filed an amicus curiae brief in support of our position.

Since we are a local pharmacy organization all of our legal fund has been depleted by the cost of this fight. We need financial help on this costly legal battle. If you agree with us, can we count on your support?

Contributions can be mailed to the Jefferson County Pharmaceutical Association (J.C.P.A.) Legal Fund, P. O. Box 57024, Birmingham, AL 35259.

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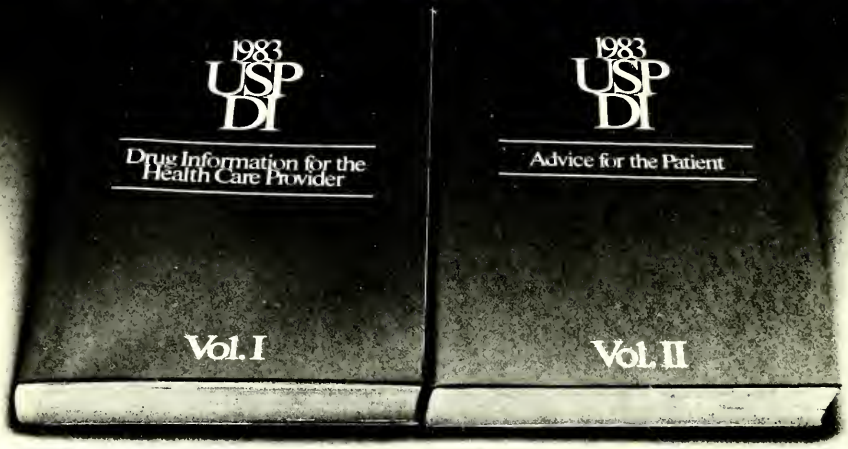

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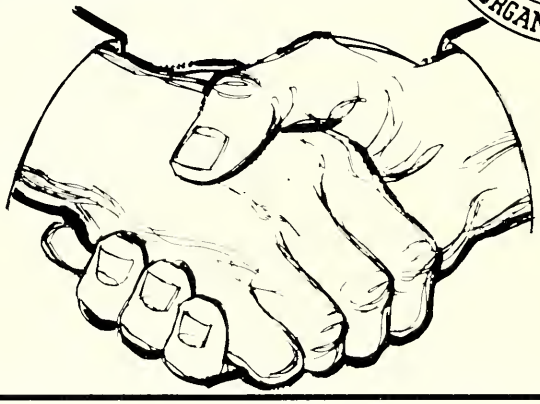

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SCHOOL OF PHARMACY
UNIVERSITY OF
NORTH CAROLINA
AT
CHAPEL HILL

ScRipt

DEAN'S MESSAGE

Reaction vs. Proaction

"Wilson, N. C., May 17th, 1880

Dear Sir:

Seeing that the N. C. Medical Society has appointed a committee 'to memorialize the Legislature upon a law requiring that Druggists shall have a license from the State Board of Medical Examiners as a requisite qualification for dispensing Medicine,' and recognizing the necessity for some law upon the subject, we have taken the liberty of addressing you and asking your views.

"We think the next Legislature will pass some law upon the subject, and we prefer that the Druggists of the State, and not the Doctors, shall attend to the matter.

"For the above and other reasons, we propose that the Druggists of the State meet for the purpose of forming a Pharmaceutical Association, and then memorialize the Legislature ourselves.

"We believe all that is needed is for somebody to put the ball in motion, so we have presumed to give it a start. We would suggest on or about August 10th or 11th as the best time, and Morehead City, Wilmington, Raleigh, Goldsboro, Greensboro or Charlotte as the best place.

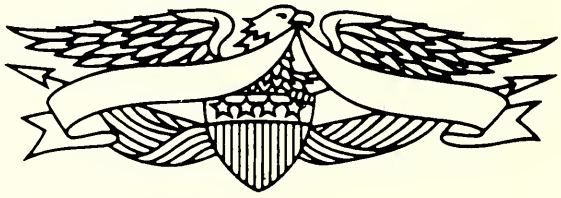
"If you will address us stating your views and the place you prefer, we will have the time and place published and try to be there and help to perfect an organization.

"The place receiving the approval of the greatest number will be selected. Hoping to hear from you by return mail, if possible.

We remain, yours very truly,
MOYE & NADAL,
A. W. ROWLAND,
PEACOCK & HARGRAVE.

This letter (printed in the Preface of the Proceedings, N. C. Pharmaceutical Association, 1880) led to the formation of the North Carolina Pharmaceutical Association at the convention held in Raleigh on August 11, 1880.

Over a hundred years later we still have a tendency to be reactive rather than proactive. Schools, including ours, are just now becoming more proactive. With rapid changes taking place in pharmacy—new drugs and devices, computerization, marketing techniques, increasing volume of OTC drugs, women in pharmacy—new initiatives will be required by pharmacy and pharmacists to advance the cause of the profession even to maintain the status quo.



CASTO JOINS FACULTY

The School extends a very warm welcome to Daniel T. Casto, who has recently joined the faculty as Assistant Professor in the Division of Pharmacy Practice. He received his Bachelor of Arts degree in Chemistry from the University of Richmond (1974); Bachelor of Science in Pharmacy, Summa Cum Laude, from Florida A and M University (1977); and his Doctor of Pharmacy degree from the University of Texas at Austin and the University of Texas Health Science Center at San Antonio (1980).

In San Antonio he served as Consultant and Acting Director of the Drug Information Service, much of his work being seizure disorders and anticonvulsants. Here at UNC, he has just begun working with the Cystic Fibrosis Team at North Carolina Memorial Hospital. Dr. Casto is particularly interested in antibiotic therapy in cystic fibrosis patients.

"Historically," said Dr. Casto, "patients with CF were all pediatric. There has been a new development in the past few years, such that the prognosis is much better. A large percentage of patients diagnosed as children with CF have a greater life expectancy than they did years ago—some even living well into adulthood."

In early October, Dr. Casto received a $1500 grant from the Pharmacy Foundation of N. C. for developing an *in vitro* pharmacokinetic model that can be used to evaluate different combinations of antibiotics against various organisms. "For instance," said Dr. Casto, "if a patient needs both gentamycin and ampicillin, we need to look into whether it matters which is given first, or how far apart to space the dosing."

When not working long hours on campus, Dr. Casto enjoys good music, tennis, and a number of outdoor activities. His wife is Maria Valdes, an elementary school teacher who is now at home with their two small boys.

Daniel T. Casto, Pharm.D.

WITH THE FACULTY

It is time to catch up on what our faculty have been doing.

MR. STEVE ALMOND, Clinical Assistant Professor in the Division of Pharmacy Practice, gave a talk on September 2 in Chapel Hill to two fourth grade classes at Seawell Elementary School on the topic on "First Aid Procedures that You can do."

MR. STEPHEN M. CAIOLA, Associate Professor in the Division of Pharmacy Practice, attended the Federation Internationale Pharmaceutique in Copenhagen, Denmark on September 6-10. He presented a paper co-authored with MR. FRED ECKEL entitled "The Future of Hospital Pharmacy in the United States in the Light of Developments in Primary Health Care."

Mrs. CAROLYN W. CAPOWSKI, Clinical Instructor and Director of Public Relations, Division of Pharmacy Administration, gave a presentation on the Vial of Life at the Fall Convocation of the Woman's Auxiliary of the NCPhA held in Chapel Hill on October 5.

Mr. FRED ECKEL, Professor and Chairman, Division of Pharmacy Practice, also attended the Federation Internationale Pharmaceutique in Denmark. He presented a paper entitled "Impact of Primary Care on Hospital Pharmacies in the United States." MR. ECKEL also spoke on "Stress and the Pharmacist" at the Wilson Pharmacist Association in Wilson, North Carolina on September 19. Earlier he presented a paper "The Resident as a Total Person" at the American Society of Hospital Pharmacist's Residency Preceptors Conference in Washington, D. C. on July 19-21.

DR. B. W. HADZIJA, Associate Professor in the Division of Pharmaceutics, was the guest speaker at the Kappa Epsilon luncheon on August 18. DR. HADZIJA spoke on "Pharmacy as Your Future Profession."

DR. ABRAHAM HARTZEMA, Assistant Professor in the Division of Pharmacy Administration, served as the Coordinating Reviewer for the Health Services Research and Development Service of the Veterans Administration in Washington, D. C. He also received a $1627.00 grant for the American Association of Colleges of Pharmacy to study outcome measurements for Pharmacists in the management of patients with chronic illnesses. On July 13, DR. HARTZEMA presented "A Model of the Utilization of Prescription Drug Knowledge" at the 18th Annual Meeting of the Drug Information Association in Kansas City, Missouri.

MS. PATSY HUFF, Clinical Assistant Professor in the Division of Pharmacy Practice, spoke on "Drug Use in Pregnancy and Lactation" at the Wake Medical Center on July 21. MS. HUFF also attended the North Carolina Society of Hospital Pharmacists Annual Clinical/Hospital Pharmacy Seminar in Greensboro on September 16. She gave a presentation on "Lactation and Oral Contraceptives."

DR. TIMOTHY IVES, Clinical Assistant Professor in the Division of Pharmacy Practice and Family Medicine spoke on "Perspectives in Bumetanide" at Roche Laboratories in Nutley, New Jersey on August 13.

MR. CLAUDE PAOLONI, Associate Professor in Continuing Education and Area Health Education Centers Programs attended the District III—National Boards of Pharmacy/ American Association of Colleges of Pharmacy Annual Meeting in Gulf Shores, Alabama on August 15-17.

DR. ROBERT SHREWSBURY, Assistant Professor in the Division of Pharmaceutics, attended the Drug Information Association meeting in Kansas City, Missouri on June 13-16. He presented a paper on the "Development of a Computerized Drug Interaction Data Base (Medicom) for Use in a Patient Specific Environment." The paper was co-authored with Dr. Arthur Shinn and Mr. Ken Anderson. DR. SHREWSBURY also attended the Post-Graduate Seminar Series held at the University of Kentucky College of Pharmacy in Lexington, Kentucky on October 7-10.

DR. C. EDWIN WEBB, Clinical Assistant Professor in the Division of Pharmacy Practice and Family Medicine, presented a paper entitled "The North Carolina AHEC Program" to the National AHEC Conference in Denver, Colorado on August 9-11. He was also elected Executive Secretary of the Western Carolina Pharmacy Association.

DR. JACK WIER, Associate Professor in the Division of Medicinal Chemistry, served on the Executive Committee at the American Society of Pharmacognosy held in Pittsburgh, Pennsylvania on July 31-August 6.

Best tailgate party in town.

FALL ALUMNI REUNION

Good fellowship. Good program. Good food. All were the order of the day as over 200 UNC Pharmacy Alumni and guests returned to Chapel Hill on September 25, to attend a seminar by Linda Pulliam on Time Management, to eat barbecue, and to watch the UNC Tarheels beat Army.

The next Alumni Association meeting will be on Commencement Weekend, May 14 and 15. Make plans now to attend. You won't want to miss it!

Nearly a full house. Your Alumni Association is growing by leaps and bounds.

DRUG INFORMATION REPORTS

John Kessler, Pharm. D.
Drug Information Center
North Carolina Memorial Hospital

What are the recommendations regarding breast feeding when a patient is to receive high dose Flagyl® ?

Flagyl® (metronidazole) is prescribed as the drug of choice in the treatment of trichomoniasis. While several dosage regimens are known to be effective, currently, single 2 Gram doses are being prescribed because of their simplicity.

Flagyl® distributes readily into breast milk in concentrations similar to that in the serum. Because of the potential for carcinogenicity and mutagenicity, it is not currently recommended that a woman breast-feed her infant while receiving Flagyl®.

Based on initial pharmacokinetic studies in lactating women, it appears that if breast-feeding is withheld for approximately 24 hours, the infant will be exposed to minimal amounts of metronidazole (< 4 mg.). Breast milk should be expressed during that 24-hour period and discarded. Formula feeding may be substituted during that time.

Reference:

Erickson, S. H., Oppenheim, G. L., Smith, G. H., *Obstetrics and Gynecology,* January 1981, Metronidazole in Breastmilk, Vol. 57: 48-50.

BE A WINNER, TOO!

Congratulations to KEITH FEARING, JR. of Manteo, N. C., a member of the School's Class of '44. He has been enjoying a pair of UNC TARHEELS season football tickets which he won in the Pharmacy Foundation's Dean's Council drawing earlier this year.

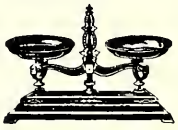
You, too, can have an opportunity for free football tickets for next season. Simply, join the Dean's Council by sending your donation of $150 or more to the Pharmacy Foundation. Mail your checks to Pharmacy Foundation of North Carolina, Inc., UNC-CH School of Pharmacy, Beard Hall 200H, Chapel Hill, N. C.

Of course, the Pharmacy Foundation is part of the CAG (Carolina Annual Giving) combined gift and all donations are tax deductible. Help us continue to help the students—an investment in your future.

OPEN HOUSE

On October 2, the School held an open house for all the undeclared majors in the University and presently in their sophomore year, the prepharmacy students in general college, and the freshmen with a projected GPA above 2.5 who have not declared a major. The morning event included exhibits by all five divisions of the School, self-guided tours, and booths from many student organizations. Nearly all faculty and many current students were on hand to greet the guests.

The open house was conceived as part of the recruitment efforts to increase the applicant pool for the coming year. All who came were very pleased. Many faculty in the School said, "We were very favorably received with a steady stream of students visiting our display throughout the entire morning." Pharmacy students who participated said "This morning has really given us a good feeling about the spirit of the School." All said, "Let's do it again!"



EMBROIDERED PATCHES

It's that time of year again . . . SAPhA is getting the fall started by planning a health education campaign. This year's campaign is on Alcohol and Drug Abuse. To help the project become self-supporting, SAPhA is selling the attractively embroidered Carolina blue and white shoulder patches (see photo) for $2 each or 3 for $5. (You may have seen them before and wondered where to order them.)

To get yours, make your check payable to SAPhA, and mail to:

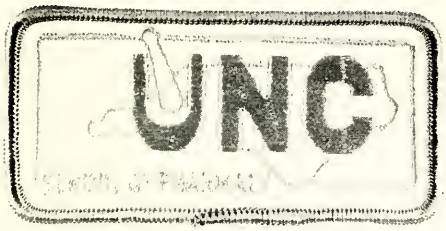
Pharmacy Emblems
UNC-CH School of Pharmacy
Beard Hall 200H
Chapel Hill, N. C. 27514

Please make sure to tell us how many emblems you would like, and remember to include your return address. And while you're at it, why not order some for your pharmacy friends as a holiday gift?

Leonard G. Phillipps, Jr.

PHILLIPPS PROMOTED

Leonard G. (Len) Phillipps, immediate past-president of the Traveling Members Auxiliary of the NCPhA, has been promoted to Eastern Sales Manager, Prescription Products, Owens-Illinois. Len is active in the similar auxiliaries of many southeastern states, and has served as president of several of them. Len and his wife Jo live in Woodstock, Georgia.



Order your embroidered emblems now! (See related article)

THOUGHTS ABOUT MIDDLE AGE

"Every man over 40 is a scoundrel."

"Boys will be boys and so will a lot of middle-aged men."

"Middle age is when you begin to exchange your emotions for your symptoms."

"Middle age is the time when a man keeps on thinking in a week or two he will feel better."

"One of the many things nobody ever tells you about middle age is that it is such a nice change from being young."

"Middle age occurs when you are too young to take up golf and too old to rush the net."

"Any views are unimportant if they are held about women by a man past 40."

"Middle age is when the young complain to you about the old and the old complain to you about the young."

"A certain friction between the generations is inevitable. That's because the young and the old have all the answers, and those in between are stuck with the questions."

"You've reached middle age when all you exercise is caution."

"You've reached middle age when your wife tells you to pull in your stomach and you already have."

"Middle age is the period when your children leave you one by one and return two by two."

"Middle age is when you have a choice of two temptations and you choose the one that will get you home earlier."

"Middle age is that preplexing time of life when we hear two voices calling us, one saying 'Why not?' and the other, 'Why bother?' "

"A mother knocked on her son's bedroom door and said, 'Son, get up and let's go to church.' She went on about her morning duties and a few minutes later returned to her son's bedroom door and said again, 'Son, get up and let's go to church.' "This time she heard the sound of her son's feet on the floor, and she stood outside the door for a few minutes to make sure he was up and about. "Then she heard him say, 'Give me three good reasons why I should get up and go to church.' "She thought for a minute and said: 'Well, it's Sunday. You're 40 years old. And you're the pastor of the church."

LOCAL NEWS

GUILFORD COUNTY SOCIETY OF PHARMACISTS

The regular monthly meeting of the Guilford County Society of Pharmacists was held Wednesday, October 13, 1982 at 8 PM in Conference Rm 6724 of Moses H. Cone Memorial Hospital with President Steve Saxe presiding.

Guest speaker for the evening was Peter Gal, Pharm D., Greensboro AHEC Pharmacist, whose talk was about "Drug Effects on the Fetus and Newborn."

During the business session following the program, President Saxe informed the membership that the local Red Cross chapter had undertaken the "Vial of Life" program and had asked for help from the Society in providing the prescription vials necessary to implement the program. Frank Burton volunteered to canvass the retail pharmacies for support in providing these vials.

Respectfully submitted,
J. Frank Burton, Sec.-Treas.

ERWIN

Erwin Drug Company has obtained the prescription files of the Erwin Drug now out of business. Owned and operated by Neil McPhail, Erwin Drug Co. has been in business for just over one year.

ROCKY MOUNT

Lamar Seats, a 1978 graduate of the UNC School of Pharmacy, has joined Eli Lilly and Company as a sales representative in the Rocky Mount area. Seats is a native of Mocksville and was associated with Community drug of Winston-Salem before joining Lilly.

WINSTON-SALEM

Gilbert R. Hartis, Jr., Winston-Salem, has been named as a director of the North Carolina Merchants Association for a three year term. Hartis is a Regional Vice-President with Revco Drug Stores.

PHARMACY TECHNICIAN CLASS

Mitchell Community College is offering a 120-hour course entitled Pharmacy Technician at Lowrance Hospital in Mooresville. The course will run from September 9 to January 20; Hugh Caldwell will serve as class instructor. The course is designed to prepare participants to assist pharmacists in the dispensing of medicines.

MORGANTON

Morganton Drug Store has purchased Community Pharmacy from the G. B. Propst estate and will combine the two stores at the Morganton Drug location. Morganton Drug is owned and operated by Tom Digh and John David Hood.

NEW AHEC PHARMACIST

Dennis Williams, pharmacist from Louisville, KY has recently joined the Tarboro Area Health Education Center (AHEC) as associate director of pharmacy and public health activities. Williams received his BS in Pharmacy degree and his Pharm.D degree from the University of Kentucky School of Pharmacy. He was a staff pharmacist at the University of Kentucky Hospital, an instructor at the school of pharmacy, and a clinical pharmacist in the primary care center in rural Kentucky. The Tarboro AHEC serves the counties of Edgecombe, Halifax, Nash, Wilson and Northampton.

MORRISVILLE

Morrisville Mayor, C. B. "Benny" Ridout, resigned to move into a larger home just outside the city limits according to *The Raleigh News and Observer*. Ridout suggested that he might run for Mayor again if the town annexes his new home. He had delayed moving because he wanted to help complete financing for a one and one half million dollar sewer system for the town.

PHARMACY RELATED CRIMES

SALISBURY

For the second time in six weeks, an employee of Revco Drug Store was robbed while making a night deposit. $1,346.00 was taken about 5:30 p.m. when the employee prepared to use the depository, accompanied by her husband and another store employee, in June. The employee was approached by a man with a pistol who took the bank bag and fled on foot.

ASHEBORO

Rite Aid Pharmacy was entered the morning of June 22 and the entire safe was stolen. Cash from the registers was also reported stolen. The thieves entered a nearby FCX Farm and Garden Supply store and stole the tools necessary to knock a three-foot by three-foot hole in the wall of the Rite Aid store, through which they carried the safe.

HIGHLANDS

Highlands Rexall Pharmacy was broken into in June and a large quantity of merchandise and drugs was reported stolen. According to Jack Alexander, pharmacist, the break-in occurred between midnight and 5 a.m. Entry was made through the front windows, and the intruders left through the front door. Valium, Percodan and other drugs were taken, along with watches and Cross Pen sets.

ROCKY MOUNT

Two bottles of Valium valued at $175.00 were reported stolen from Thompson's Pharmacy, Friday, July 9. Police believe the building was entered through a skylight on the roof, but only Valium was taken.

SALISBURY

Valium tablets worth $100.00 were reported stolen from Towne Pharmacy Saturday, August 21.

ROCKY MOUNT

Someone tried to enter Sunset Pharmacy through a hole cut in the roof early Wednesday, June 30, but was apparently frightened off by the alarm. Nothing was reported missing from the pharmacy.

DURHAM

Revco Drug Store was entered through the roof late in August, but an alarm apparently frightened the intruders off before anything could be taken. Police said the burglars pulled the side from an air-conditioning unit and crawled it and came through a ceiling panel into the store. They got out of the store by pushing a shopping cart through the glass front door.

WAKE FOREST

Thieves broke into the office of a Wake Forest physician and stole vaccines and other medicines. Polio vaccine and snake-bite antivenom were among the drug products reported stolen over the July 4th weekend.

CLINTON

Clinton police have discovered forged prescriptions for Desoxyn in two local pharmacies in late July. The prescriptions were forged using the name of Dr. D. W. Creed of Elizabethtown.

PITTSBORO

Sixty dollars worth of Dilaudid and Cocaine were stolen from Chatham Rexall Drug Thursday, August 8. Willis Whitehead said he believed two black males seeking medication for a cut foot were involved.

DANBURY

Two Stokes County residents have been arrested and charged with attempting to pass forged prescriptions at the Stokes Pharmacy on August 7. Forged prescriptions were for Darvocet and Ecotrin.

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STATESVILLE

An organized ring obtaining prescriptions for Talwin for non medical purposes was uncovered by Iredell County law officers in the middle of August. At least two persons have been arrested in connection with the illegal prescription ring. A woman would telephone a Statesville physician at home and use a fictitious name, and request a prescription for Talwin. When the physicians checked their records at the office, the scheme was discovered.

REIDSVILLE

A man wearing a ski mask attempted to take drugs from Annie Penn Memorial Hospital in Reidsville in June, but fled without any drugs according to local police. The man entered the pharmacy about 6:00 p.m. and demanded drugs. After locking two employees in a utility room, he left the hospital without obtaining the desired drugs.

DEATHS

OSCAR L. UMSTEAD

Oscar Umstead, Durham, died in August at the age of 74. Umstead practiced in Henderson, Washington, Raleigh and Durham and owned Broad Street Pharmacy in Durham for a number of years. He was eligible to receive his 50+ pin and certificate at the 1981 Convention of the NCPhA in Charlotte, but was unable to attend.

DR. URBANO SOLER

Dr. Urbano Soler, Miami, Florida, died May 6, 1982 at the age of 84. Dr. Soler was a 1924 graduate of School of Pharmacy of the University of North Carolina. He was licensed in North Carolina in 1924 and also in Cuba, where he operated a pharmacy until December, 1961. When Fidel Castro appropriated all his propery, including the pharmacy, orange and lemon groves and a coffee plantation, Dr. Soler came to the United States and eventually settled in Miami where he lived with a son and daughter.

DAVID RALPH COPPALA

David Coppala, Charlotte, died June 9, 1982 at the age of 25. A 1979 graduate of the University of North Carolina, he was a native of Charlotte and was associated with Revco Drug Stores.

CHARL H. SANDERS

Charl Sanders, Granite Quarry, died April 5, 1982. He was 58 years old. Born in Somerville, Tennessee, Sanders operated the Granite Drug Co. since 1956. He was married to the former Patsy Burgiss, Sparta. He had worked in Sparta, Kannapolis, Concord, and Wilmington before settling in Granite Quarry.

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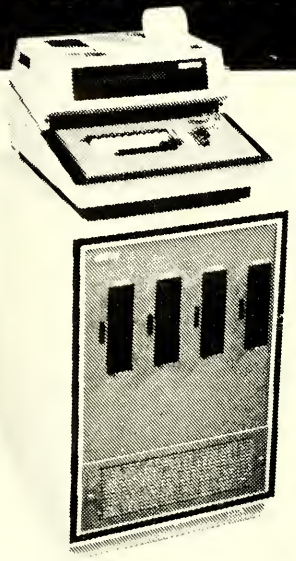

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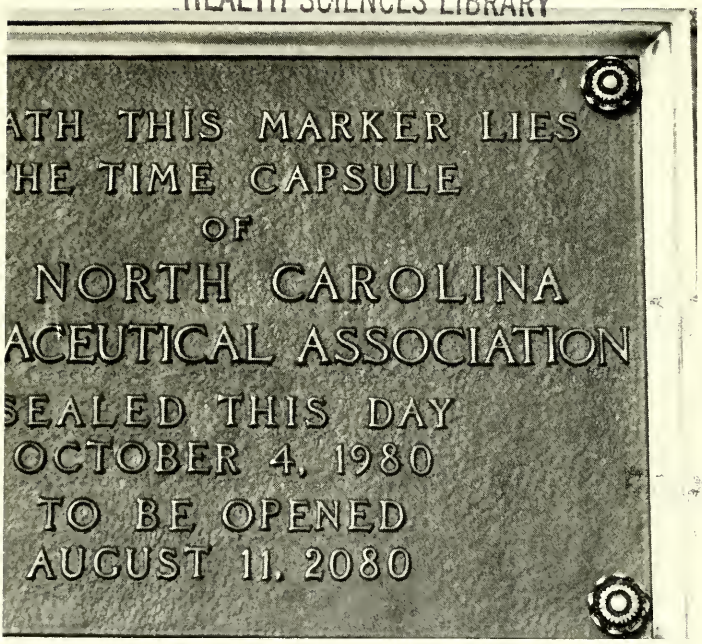

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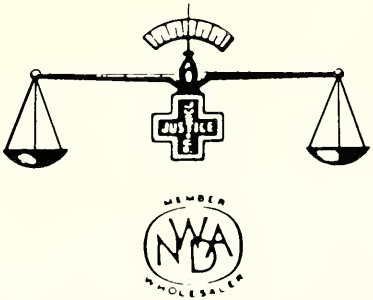

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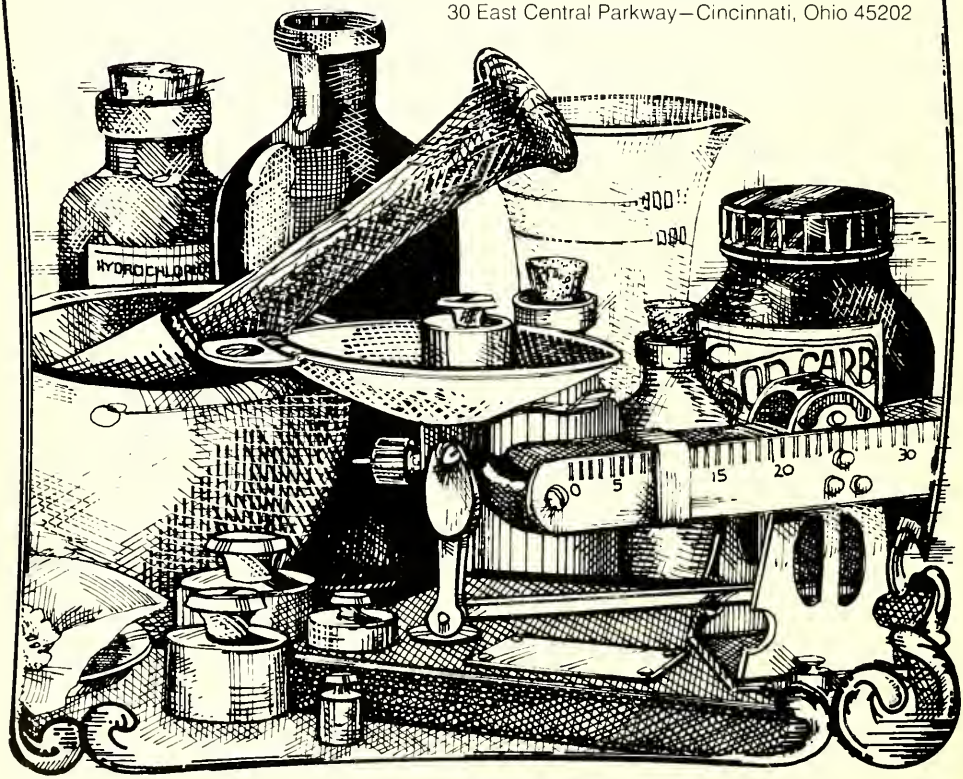

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(Continued next Page)

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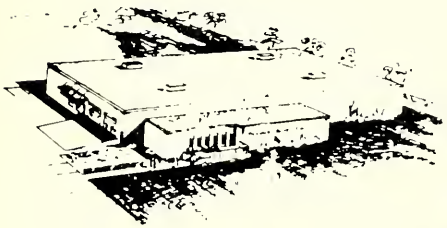

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PHARMACY CRIMES

ROLESVILLE

Valium, Tranxene and a muscle relaxant were about the only drugs stolen from Rolesville Drug Company early Monday morning, November 8, 1982. The break-in occurred after 3 am and entry was gained by breaking the front window.

FOREST CITY

An Ellenburg man was arrested in Forest City Monday, November 8, 1982, while trying to obtain Schedule II and IV drugs with forged prescriptions. The prescriptions were presented at Hardin's Drug Store.

DURHAM

A man armed with a pistol robbed McLaughlin's Pharmacy Wednesday, November 24, 1982. The robber wore a hat with a stocking that covered part of his face. He went to the checkout counter, ordered the clerk to open the register and helped himself to its contents. About $200.00 was reported taken.

LEWISVILLE

A Lewisville man arrested in Wilkes County on charges of forging prescriptions has been accused of the same crime in three other counties. The man was charged with attempting to obtain Dilaudid through forgery in Wilkes, Guilford, Davidson and Forsyth. Stolen Rx blanks and a fake telephone number which turned out to be a pay telephone were part of the scheme.

RAMSEUR

A Franklinville woman was arrested Friday night, November 12, 1982 and charged with attempting to obtain a controlled substance by fraud. According to police, the woman presented a prescription for fifteen Demerol tablets at Ramseur Pharmacy, the pharmacist became suspicious and telephoned the physician, who said the prescription was written for five tablets.

DURHAM

Thieves broke a window in Eckerd's Drug Store and stole more than $2,800 in merchandise. The breakin occurred early Saturday morning December 11. Watches, recorders and radios were reported missing.

ASHEBORO

Kearns Service Drug was victimized by "con" artists Thursday, November 12, 1982. Employees of the store, including pharmacist Ben Mobley, were distracted by three or four men posing as customers, while another member of the group opened the store's safe and stole approximately $2,400. The theft was discovered later in the day when Mobley opened the safe to cash a check.

WINSTON-SALEM

Thieves stole nearly $1,000 in cash from the Drown Drug store in Old Town on Tuesday night, November 9, 1982. The store was broken into sometime between closing Monday night and 8:15 am.

MURPHY

Police arrested three men from Tennessee just minutes after they had robbed Rite-Aid Pharmacy in Murphy, Thursday afternoon, November 4, 1982. One of the men distracted a clerk in the pharmacy while another went into the front office, opened the safe and took about $750. The third man waited in the car.

WILLIAMSTON

Davis Pharmacy was entered either late Tuesday, October 12, 1982 or early Wednesday morning and several items were reported stolen, according to Pharmacist David R. Davis. The side glass door had been broken open by a metal object thrown through the glass portion.

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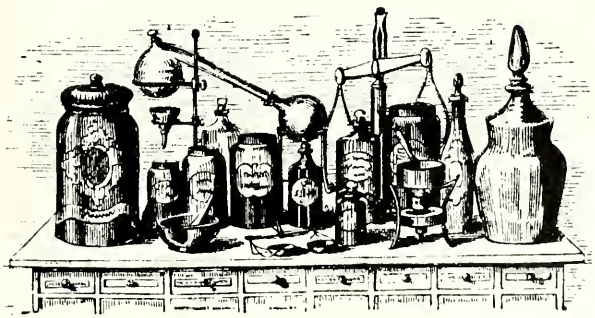

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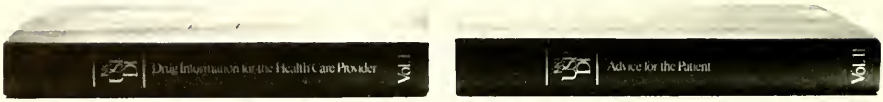

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WASHINGTON STATE PRESCRIPTIVE AUTHORITY

by Frances Rader

In Washington State, pharmacists are allowed to prescribe legend medications through the practice of prescriptive authority. They have the authority to engage in any component of the prescribing process, which comprises all activities leading up to the generation of the prescription drug order. The revised Washington Pharmacy Practice Act passed in 1979, changed the definition of the Practice of Pharmacy and allows pharmacists to participate in prescribing. All pharmacists in Washington State are eligible for prescriptive authority regardless of extent of education. Prior to prescribing, they must make application through and receive approval from the Board of Pharmacy. This authority to prescribe can only be delegated by pharmacist's educational qualifications, demonstrated knowledge, and behavior. Authority may be granted to one pharmacist or to a readily identified group of pharmacists working under supervision.

Pharmacists can exercise prescriptive authority, authority has been given via protocol signed by the practitioner. Specific guidelines must be developed according to the scope of the physician's practice; its contents must be consistent with standard or accented drug therapy. The Board must be assured that a legitimate relationship exists between the pharmacist and the prescriber, that the prescriber reviews the pharmacist's prescriptive authority, that the pharmacist is adhering to the protocol specified, and that the pharmacist is adequately documenting these activities in the prescription record, patient drug profile, patient medication profile, or in a separate logbook. The protocol and prescriptive authority agreement between the prescriber and pharmacist must be periodically reviewed, updated and renewed. Prior Board notification of written guidelines or protocol is required and be approved by a practitioner authorized to prescribed legend drugs.

The protocol must contain statements of the types of prescriptive authority decisions which the pharmacist is authorized to make; it must contain information on the types of diseases, drugs or drug classes where authorization is granted. Also included are general statements concerning the procedures, decisions criteria, or plan the pharmacists are to follow when making therapeutic decisions (epsecially when pharmacists modify or initiate drug therapy), when documenting decisions made, and when communicating feedback.

The prescriptive authority used in Washington State could also be implemented in North Carolina. If successful, it would benefit the pharmacists, patients and physicians. By exercising prescriptive authority, the pharmacist could increase services rendered to patients, save the patient time and money in acquiring the physicians' permission for substitution or refills without phone calls or office visits, and could increase public image of the profession of pharmacy. Decreasing the number of office visits through the prescriptive activities of the pharmacist would allow the doctor to utilize his time more wisely with more seriously ill patients (or for relaxing on the golf course). This prescriptive authority could especially be advantageous in ambulatory care clinics, family practice centers, or rural areas when doctors are scarce.

For those pharmacists and physicians who are apprehensive about pharmacists prescribing, legislative action would allow only those pharmacists qualified by a physician to prescribe. Depending on the pharmacist's rapport with the physician, a pharmacist who can demonstrate his knowledge and expertise should have no problems being sponsored. Not all pharmacists would need or feel the need to prescribe, clinical monitoring. Even so, the pharmacists who fear prescribing, could confidently use prescriptive authority by following the specified guidelines written in the protocol.

While pharmacists' prescribing would make the health care delivery system more efficient in North Carolina, answers to certain questions must be found before the advantages of prescriptive authority can be realized. Who is most liable for malpractice? The sponsoring physician or the pharmacist who follows the protocol? Equally liable? What would be the liability for the doctor and pharmacist if the pharmacist did not follow the protocol? Since the pharmacist must document every decision, would the pharmacist be more likely to be negligent? Another

(Continued on Page 17)

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WASHINGTON STATE

foreseeable problem is the acceptance and support from the North Carolina Medial Association. Is the Association progressive enough to recognize the benefits of prescriptive authority vs the transfer of their prescribing power? Some Doctors are disenchanted with optometrists, physicians assistants and family practice nurses prescribing. Why should they desire to allow pharmacists to prescribe even if they are the drug experts?

There might be problems associated with reimbursing the pharmacist for his services. Will the patient and /or physician be willing to reimburse the pharmacist for his prescribing activities? Will these activities be recognized by Medicare and Medicaid?

Lastly, will the pharmacist desire to be subservient to physicians for his prescribing activities. Should pharmacists be allowed to prescribe on their own.

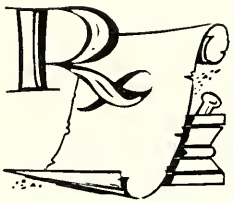
In effect, the prescriptive authority would benefit the populus of North Carolina by improving the health care delivery system. But certain answers must be found for the issues in liability, reimbursement and pharmacy subserviency before the prescriptive authority's potential can be fully realized.

Frances L. Rader received her Masters in Pharmacy Practice in 1982 from the UNC School of Pharmacy. She is currently serving as Executive Resident for the North Carolina Society of Hospital Pharmacists and the North Carolina Pharmaceutical Association.

NWDA AND NARD TO CO-SPONSOR FINANCIAL MANAGEMENT PROGRAMS FOR RETAIL PHARMACISTS

The Executive Committees of NWDA and the National Association of Retail Druggists held a joint meeting in Alexandria on November 20 to discuss subjects of mutual interest and concern. On the agenda were such topics as NWDA's efforts to terminate the MAC program, retailer buying groups, wholesaler bulk warehouse sales, hospital bid contracts, tamper-resistant packaging and inventories, recalls and return goods, third party programs, and wholesaler services to retailers. While NWDA and NARD were not entirely in agreement on all matters discussed, the dialogue unquestionably resulted in improved communication and better understanding.

One specific accomplishment was agreement that the two associations will co-sponsor the development of an educational program on financial management to help pharmacists operate their businesses more effectively. Each group will appoint a committee of three individuals to work together to design a pilot program, which, if successful, will be presented on dates and locations to be determined. Details will be announced as soon as available.



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LOCAL NEWS

WILLIAMSTON

New officers of the Northeastern Carolina Pharmaceutical Association for 1982-83 are: James B. Bryant, Washington—President; Wallace E. Nelson, Edenton—Vice-President; and J. Robert Bowers, Bethel—Secretary-Treasurer. The new officers were installed at the annual Christmas party held at Roanoke Country Club, Sunday, December 5, 1982.

ROCKINGHAM COUNTY

The Rockingham County Society of Pharmacists met at the Margre Restaurant Sunday night November 21st. The following officers were elected for the calendar year 1983. President—Mary Ann Edwards; Vice-President—Arnold Britt; Secretary Treasurer—Cheryl Kendrick.

GUILFORD COUNTY

The regular monthly meeting of the Guilford County Society of Pharmacists was held Tuesday, November 9, 1982, at 8:00 pm in the AHEC conference room at Moses Cone Memorial Hospital, Guest speaker was Karen Oles, Pharm. D. a Northwest AHEC Pharmacist. She talked about "New Benzodiazepines and Antidepressants," reviewing the newer drugs in this important class and comparing their characteristics to the older more established benzodiazepines.

A short business meeting was held following the program, and the meeting was adjourned.

DON'T MISS the article by Jean Paul Gagnon, UNC School of Pharmacy, in the November 1, 1982 issue of *Drug Topics*. The article, *In pursuit of just third-party compensation*, promotes strategies for obtaining adequate compensation for pharmacy services.

NCShP HONORS BILL ADAMS

William R. Adams, Jr. director of pharmacy of Wilson Memorial Hospital in Wilson, has been honored as Pharmacist of the Year by the North Carolina Society of Hospital Pharmacists.

The award was presented to Adams, a native of Johnston County, at the society's annual Fall Seminar September 17 at the Holiday Inn Four Seasons in Greensboro.

The award is based on high moral character, good citizenship, and high professional ideals. Nominees also must have made significant contributions to hospital pharmacy in the form of sustained exemplary service or an outstanding single achievement.

Adams, who earned the bachelor of science degree in pharmacy at the University of North Carolina at Chapel Hill, has been a resident of Wilson for 26 years and director of pharmacy at Wilson Memorial since 1964.

He is the first hospital pharmacist to serve as a member of the North Carolina Board of Pharmacy, having served from 1972 to 1974 and from 1977 to the present. He served two terms as president of the board, and currently is vice-president.

He has been a member of the National Association of Boards of Pharmacy's Licensing Examination Committee from the beginning to his state board experience, and currently is chairman of the committee, which is responsible for the examination that is administered in all 50 states for the purpose of licensing pharmacists.

Adams, a graduate of Four Oaks High School, is the son of Mrs. W. Robert Adams of Rt. 3, Four Oaks. He and his wife Alice are the parents of four children.

HILLSBOROUGH

Evelyn P. Lloyd, pharmacist at James Pharmacy, has been re-elected chairman of the Orange County Board of Health. Miss Lloyd has served on the board for approximately four years.

THE LILLY DIGEST—THEN AND NOW

An idea was born 50 years ago . . .

They were difficult times—some said the worst they had ever seen—and the year, 1932, held little promise, little hope for many depression-racked Americans. The depths of an era characterized by corner apple sellers, rusting equipment, and long breadlines were still not plumbed. Large corporations, and small businesses alike were struggling for their very survival, and the outlook was bleak.

Somehow, in the face of failure and despair, the country reached deeply and drew on a stubborn will to continue—to weather the storm. Encouragement came from many sources, but tangible support was far less evident.

Retail pharmacy was hit hard. Over 60,000 pharmacists owned their own businesses, and the ranks thinned as, one after another, they closed their doors. And with each shuttering, a number of Americans were denied access to the pharmaceutical preparations on which they depended.

Mr. Eli Lilly, himself a pharmacist and president of Eli Lilly and Company, a manufacturer of pharmaceuticals, was alarmed by the catastrophe confronting retail pharmacists and decided to do something about it. He rightly concluded that pharmacy was the final step in the supply of therapy to patients and that, without pharmacy services, the well-being of Americans, at a time when all their strength was needed, would suffer. But, what to do?

Pharmacists were businessmen, Mr. Lilly declared, and this was the discipline on which success or failure depended. Why can't we offer managerial assistance to pharmacists so that they may better understand and solve their problems? An idea was born!

Mr. Lilly contacted his alma mater, the Philadelphia College of Pharmacy and Science, and talked with a young, bright pharmacy professor, Dr. Paul C. Olsen. Dr. Olsen quickly saw the value of Mr. Lilly's plan, and the idea moved closer to action.

Dr. Olsen analyzed 271 pharmacy financial statements, and the pharmacists who were the recipients of his advice were indeed helped. The idea then occurred to publish the results of these analyses so that the thousands of pharmacists who did not participate in the program could use the report to manage their pharmacies more efficiently. The *Lilly Digest* became a reality!

Throughout the depression, World War II, and the economic swings that followed, the *Lilly Digest* continued to be published. Now, half a century later, it is larger and more complex, perhaps in keeping with the expanding nature of the profession it reflects. However, its primary objective remains unchanged—to assist community pharmacy owners in the management of their businesses.

The individual analyses provided to each pharmacist who submits data have also grown and are a useful review of the business year. Through comparisons with the averages of other similar pharmacies, managers can better understand their operations . . . yes, the idea born 50 years ago has stood the test of time.

Many changes are seen in the pages of the *Lilly Digest*. The emergence and blossoming of chain pharmacies, the dramatic growth of independents, the remarkable and lasting strength of the prescription department, the virtual elimination of fountains, and the dominance of open shelving are major shifts that have occurred during the past five decades.

Yet, the objective established 50 years ago for the first *Lilly Digest* still applies to the environment for retail pharmacy practice—its use as a comparative reference by drugstore management to improve profitability. To meet this objective, the *Digest* had to be organized in such a manner as to allow for the identification of specific areas within the pharmacy's operation and to provide benchmarks for comparison so that the management decision-making process would, in fact, be supported by improved profitability. A quote from the 1932 *Lilly Digest* embodies this idea: "it points out the common weakness of drugstore management and offers solutions to some of the many perplexing problems that baffle endeavors to do business at a profit."

The *Lilly Digest* was then, and is now, a cross section of the independent retail pharmacies in the United States, free from bias or selfish motive. It is an account of actual

(continued next page)

drugstore operations and, when used on an individual comparative basis, will provide management with data that are both beneficial and inspirational. As was said a half century ago: "much has been written about the things a retail druggist needs to do to increase the profits of his store. Anyone will agree that a druggist who was capable of earning extraordinary profits in 1932 is capable of earning extraordinary profits in any year." What was suggested by this statement is a worthwhile credo for retail pharmacy managers today—it is vital to the success of the business that management employ the necessary means to evaluate their operation objectively so that the greatest profit performance can be realized. The *Lilly Digest* has continued to work toward being one tool to use in this evaluation process.

It is astounding to look at the operating figures gathered for pharmacies during 1932 and to compare them with today's statistics. Those readers who remember the "difficult years" and those who began practice long after the great depression will find them interesting!

Selected operating figures for pharmacies reporting to the *Lilly Digest* in 1932 and 1982 are presented in Table 1. Since prescription department statistics were not collected until 1938, the data relevant to this phase of pharmacy operations will be discussed on the basis of information presented in Table 2.

Total sales showed a 19-fold increase over the 50-year period (Table 1). It is particularly interesting to note that the figures for cost of goods sold and gross margin, as a percent of sales, are virtually the same in 1982 as in 1932. Total expense percentages were also quite similar although somewhat higher in 1982, with the result that net profit is lower in the current year. Within the total expense

Table 1
Selected Operating Data for *Lilly Digest* Pharmacies
1932/1982

	1932 (271 Pharmacies)	**1982 (1,750 Pharmacies)**
Total sales	$23,108—100.0%	$439,133—100.0%
Cost of goods sold	15,153— 65.6%	288,421— 65.7%
Gross margin	$ 7,955— 34.4%	$150,712— 34.3%
Total wage package	$ 4,196— 18.1%	$ 78,672— 17.9%
Rent	986— 4.3%	10,886— 2.5%
Miscellaneous operating costs	1,841— 8.0%	47,181— 10.7%
Total expenses	$ 7,023— 30.4%	$136,739— 31.1%
Net profit	$ 932— 4.0%	$ 13,973— 3.2%
Inventory turnover rate	2.9 times	4.3 times
Inventory at cost	$ 5,285— 22.9%	$ 68,768— 15.7%

Table 2
Prescription Department Comparison
1938/1982

	1938 (542 Pharmacies)	**1982 (1,750 Pharmacies)**
Total sales	$30,369—100.0%	$439,133—100.0%
Prescription sales	$ 3,767— 12.4%	$239,561— 54.6%
Other sales	$26,602— 87.6%	$199,572— 45.4%
Prescriptions dispensed	4,232	27,225
Average prescription charge	$0.89	$8.80

category, miscellaneous operating expenses were higher as a percent of sales and more than offset the decline in total wages and rent. This may be explained partly by the fact that business today is more complex and the typical drugstore operation is more sophisticated than it was five decades ago. Inventory turnover rate and inventory at cost figures improved significantly over the period, perhaps because of improved managerial expertise as well as the growth and development of more efficient merchandise distribution systems.

That inflation is a real force to reckon with can be shown by these statistics: It takes $7.00 today to purchase what one dollar purchased in 1932. In other words, 1982 dollars represent only about 14 cents of 1932 dollar purchasing power.

Table 2 indicates that the prescription department has grown in influence within the average *Lilly Digest* pharmacy over the period (from 12.4% of sales to 54.6%). The data suggest that stores in the late thirties were essentially merchandise-oriented operations, whereas those of recent times have depended heavily on the prescription department to sustain the business. Further review of the information in Table 2 reveals that the number of prescriptions dispensed increased more than six times over this period and the average prescription charge rose about ten times, with the result that the total prescription revenue is about 63 times greater than in 1938.

Yes, what emerged from an idea 50 years ago has evolved into a publication that serves the pharmacy profession as an effective management decision-making tool. The practice of pharmacy and the *Lilly Digest* have expanded to meet the growing needs of the public and professionals. The pharmacist's continued participation in serving the health needs of Americans is a certainty and the availability of the *Lilly Digest* as a resource for the business management needs of the practicing pharmacist has been and will continue to be a goal of Eli Lilly and Company.

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WORKING WOMEN CAUSE CHANGE IN COLLECTIONS INDUSTRY

The influx of women into the work force has brought about many changes—even the methods used by collection agencies have been affected.

With over half of all adult women now working, collectors find a large percentage of the phone calls made during the day go unanswered. All those phones ringing in empty homes have forced modern collection services to devise alternate strategies.

I.C. System, the collection service recommended for use by members, has found combining telephone and mail contacts to be the most successful means of motivating debtors to pay.

Successive mail contacts are followed up with telephone calls, most of which are placed during the early evening hours when debtors are most likely to be home. Calls are also being made on Saturdays, as I. C. System works to adapt its collection procedures to the changing lifestyles of the 1980's.

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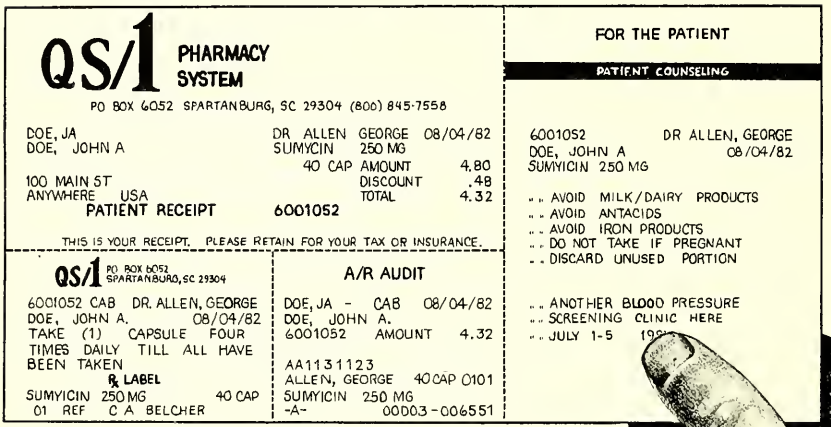

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1982 LILLY DIGEST FIGURES FOR NORTH CAROLINA PHARMACIES

Averages per pharmacy	1981 NORTH CAROLINA (30 Pharmacies)	1980 NORTH CAROLINA (47 Pharmacies)	1981 UNITED STATES Average (1,750 Pharmacies)
SALES			
Prescription	$272,806— 63.0%	64.6%	54.6%
Other	160,086— 37.0%	35.4%	45.4%
TOTAL SALES	$432,892—100.0%	$421,201—100.0%	$439,133—100.0%
COST OF GOODS SOLD	282,680— 65.3%	65.3%	65.7%
GROSS MARGIN	$150,212— 34.7%	34.7%	34.3%
EXPENSES			
Proprietor's or manager's salary	$ 29,056— 6.7%	6.1%	6.4%
Employees' wages	54,082— 12.5%	13.4%	11.5%
Rent	9,591— 2.2%	2.1%	2.5%
Miscellaneous expenses	45,555— 10.5%	9.4%	10.7%
TOTAL EXPENSES	$138,284— 31.9%	31.0%	31.1%
NET PROFIT (before taxes)	$ 11,928— 2.8%	3.7%	3.2%
TOTAL INCOME OF SELF-EMPLOYED PROPRIETOR (before taxes on income and profit)	$ 40,984— 9.5%	9.8%	9.6%
VALUE OF INVENTORY AS A PERCENT OF SALES			
Prescription	$ 27,936— 10.2%	11.3%	11.2%
Other	36,249— 22.6%	27.7%	21.0%
TOTAL	$ 64,185— 14.8%	17.1%	$ 68,768—15.7%
ANNUAL RATE OF TURNOVER OF INVENTORY	4.5 times	4.0 times	4.3 times
NUMBER OF PRESCRIPTIONS DISPENSED			
New	12,495— 41.5%	39.5%	48.6%
Renewed	17,594— 58.5%	60.5%	51.4%
TOTAL	30,089—100.0%	100.0%	27,225—100.0%
PRESCRIPTION CHARGE	$9.07	$7.27	$8.80
NUMBER OF HOURS PER WEEK			
Pharmacy was open	61 hours	63 hours	62 hours
Worked by proprietor	48 hours	48 hours	48 hours
Worked by employed pharmacist(s)	40 hours	43 hours	39 hours

*Source: 1982 *Lilly Digest*

SCHOOL OF PHARMACY
UNIVERSITY OF
NORTH CAROLINA
AT
CHAPEL HILL

ScRipt

DEAN'S MESSAGE
CURRICULUM—WHERE DO WE GO FROM HERE?

Overemphasis on clinical aspects, underemphasis on science, insufficient practice experience, overeducation . . . etc., etc. have been talked about and written about. All are correct or incorrect, depending on one's perspective.

Curriculum-building is a most difficult task, but it lies within the responsibility of academia not only to reflect societal changes, but more importantly, to change the status quo for the improvement of the profession. Like it or not, it is impossible to satisfy individual student desires and, given the nature of the practice of pharmacy, neither is it possible to satisfy all potential employers. A recent survey of our graduates indicates that about 75% of our graduates go into community or institutional practice in about equal numbers. The remaining students pursue career objectives in such areas as clinical pharmacy (Pharm.D.), dentistry, law, medicine, and business, or go on to extend their knowledge base in graduate programs leading to the Ph.D. degree.

Do you believe that we need to have a preponderance of pharmacy-trained faculty in all of our schools of pharmacy? How do we offer a good science base, let alone entice our bright students for graduate work in one of the pharmaceutical sciences? Our current trends would indicate that pharmacy-trained faculty is an endangered species. Do you believe that our students need to have good clinical exposure? Do you believe that our students need exposure to and a knowledge of distributive institutional pharmacy in all of its aspects? Do you believe our students need knowledge of inventory control, management, and the elements of law, computers, etc? Do you believe . . . enough.

There is no way in which we can educate students to the expectations of everyone in the respective areas of pharmacy activity discussed above. We do need to develop and maintain a balance of minimal competencies.

Over and above the skills necessary to operate in our complex professional environment, we need to educate our students to operate outside the professional field—the societal environment. This is attempted, as everyone is aware, by national accreditation standards as well as by our University's General College requirements.

Despite our perceptions of how we can improve our curriculum and the way we teach—and these are many and varied—our students have made marked improvements in recent years on the licensing board examination. Our pass rate today is at its highest, and in three out of the five examination categories in a recent examination—our students have always done well in the mathematics section—the scores are higher than the national average. This is indeed encouraging and should spur us to even higher standards of quality.

Curriculum development and improvement of instruction is everyone's business, including the students and the public, but the responsibility for its implementation lies primarily with the School's faculty. We must accomplish the task without encroaching on "academic freedom." On the other hand, the faculty must recognize that with academic freedom comes responsibility and accountability.

FACULTY NOTES

Several of the faculty members of the School of Pharmacy participated in the Midyear meeting of the Student American Pharmaceutical Association held at the UNC-Chapel Hill School of Pharmacy on November 6.

MR. STEPHEN CAIOLA, Associate Professor in the Division of Pharmacy Practice, and DR. BRUCE CANADAY, Clinical Assistant Professor in the AHEC Division, presided as moderators at a workshop entitled "Patient Education in Action." MR. W. JAMES BICKET, Clinical Assistant Professor in the Division of Pharmacy Practice, MS. LONI GARCIA, former Visiting Clinical Instructor in the Division of Pharmacy Practice and MS. PAMELA JOYNER, Clinical Assistant Professor in the AHEC Division participated in the Student workshop entitled "Climbing Your Way to the Top." Special interest workshops were conducted by MR. BEN WILLIAMS, Clinical Assistant Professor in the Division of Pharmacy Practice who spoke on "The Pharmacist's Role in Clinical Research," DR. DANIEL CASTO, Assistant Professor in the Division of Pharmacy Practice entitled "An Interdisciplinary Approach to the Therapy of Cystic Fibrosis," and MS. PATSY HUFF, Clinical Assistant Professor in the Division of Pharmacy Practice who spoke on "Drug Usage in Pregnancy."

DR. JAMES BUSTRACK, Clinical Asssistant Professor in the Division of Pharmacy Practice, co-authored with J. H. Hull, J. W. A. Findley, J. F. Rogers, R. M. Welch, and R. F. Butts, an article entitled "An evaluation of the effects of smoking on codeine pharmacokinetics and bioavailability in normal human volunteers" *Drug Intell Clin Pharm.* 16:849-854 (1982). DR. BUSTRACK also attended the American Heart Association, 55th Scientific Sessions in Dallas, Texas on November 15-18 and the Symposium on Noninvasive Diagnostic Techniques in Vascular Disease in San Diego, California on October 18-22.

MR. SETEPHEN CAIOLA, Associate Professor in the Division of Pharmacy Practice presented the Northwest Area Health Education Center's course on "Communication Skills for the Pharmacist" held at the Bowman Gray School of Medicine in Winston-Salem on October 21.

UNC SCHOOL OF PHARMACY EMPLOYER'S DAY

Each year the School of Pharmacy sets aside one day for prospective employers to meet with graduating students.

This day is Friday, March 25, 1983. There are approximately 125 graduating seniors, many of whom will be seeking employment. Informal interviews and personal data forms will assist employers choosing students for available positions and future positions.

Anyone wishing to participate in this program should contact—Jack K. Wier, School of Pharmacy, 919-062-0097.

SCHOOL HOSTS SAPhA REGIONAL

The UNC School of Pharmacy hosted the Region III Student American Pharmaceutical Association Midyear Meeting on November 5-7. The event was co-sponsored with the American Pharmaceutical Association and included 75 students from pharmacy schools in North Carolina, South Carolina, Georgia, Florida, Alabama, Mississippi, Tennessee, and Puerto Rico. In addition, students in allied sciences at UNC attended.

According to Mary T. Dorsey, Coordinator for Region III, "The purpose of the Midyear Meeting was to provide a forum for discussions of common interest among pharmacy students and students in other health care disciplines, and to inform students of the activities of the Pharmaceutical Association and the profession. The meeting also enabled students to learn of new developments on the health scene." Tom Burgiss of Sparta was the keynote speaker at the opening session on Friday night. The three-day event included workshops on the following topics: "The Behavioral Interview and Patient Compliance," "Drug Usage in Pregnancy," "Management and Care of the Psychotic Patient," "Drug Therapy of Cystic Fibrosis," and "Stress Management and Career Development." (see *with the Faculty*).

(continued on next page)

In addition to the workshops, students enjoyed a Friday night social at the Carolina Inn, a Saturday luncheon at the Institute of Pharmacy, and a banquet and dance on Saturday evening at the Carolina Inn. Al Mebane, Executive Director of the NCPhA was the featured speaker Saturday night at the banquet.

DRUG INFORMATION REPORTS

by Patsy Huff, BS Pharmacy

Update on Drugs Used During Pregnancy

Vaginal Spermicides—In 1981, a study reported an association between major congenital malformations and the use of vaginal spermicides at any time during the 600 days (20 months) prior to delivery. The same study reported an increased incidence of spontaneous abortion in users of spermicide. The methodology of this study has received some criticism. A later study reported that 462 pregnant women who used nonmercurial spermicides (nonoxynol-9 and octoxynol) within 14 weeks after conception had no increased rate of major birth defects. No cause/effect association has been shown between spermicide use and congenital defects. Further studies are needed with larger numbers of patients to exclude low-level risk.

Aspirin—There is no conclusive evidence to show that aspirin is teratogenic in humans. It has been implicated as a weak teratogen in retrospective studies, but prospective studies have failed to document this. Salicylate toxicity has been reported in infants whose mothers ingested excessive amounts prior to delivery. Aspirin may inhibit platelet aggregation, decrease factor XII and cause neonatal bleeding if taken near term. The FDA has issued a statement warning pregnant women not to use aspirin during the last trimester. There is a high incidence of neonatal intracranial hemorrhage in premature infants exposed in utero to aspirin. Acetaminophen is considered to be a safe alternative analgesic and antipyretic during any stage of pregnancy.

Bendectin®—Large prospective and retrospective studies have found no association between Bendectin® and birth defects. One survey suggested an association between Bendectin® and cogenital heart defects, but was not conclusive. A CDC study found no evidence for teratogenicity of Bendectin®. Two recent animal studies linking Bendectin® to diaphragmatic hernia and a cardiac defect, respectively, have led the FDA to revise the package insert to report these findings.

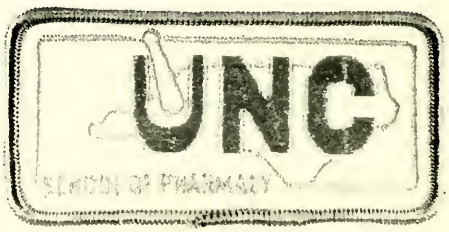
For references on further information, please contact Patsy Huff, Orange Chatham Comprehensive Health Services c/o School of Pharmacy—Beard Hall 200H, Chapel Hill.

JORDAN MEMORIAL SCHOLARSHIP CREATED

Mr. and Mrs. William M. Jordan of Nebo, North Carolina have recently established The Jeffrey M. Jordan Memorial Scholarship in memory of their son who was planning to attend Pharmacy School at the University of North Carolina. A $19,000 endowment fund established through the Pharmacy Foundation of North Carolina, Inc. (formerly North Carolina Pharmaceutical Research Foundation) will make it possible to make an annual award to a pharmacy student.

Mr. Jordan who graduated from the University of North Carolina School of Pharmacy in 1949 is co-owner of Service Pharmacy, Inc. in Marion, North Carolina.

Dean Tom S. Miya, the Secretary of the Foundation, said that it was particularly fitting that such a scholarship be established in perpetuity by the Jordans in the name of a young man who had aspired to become a pharmacist. This scholarship will serve the needs of future generations of pharmacy students—an opportunity which never came to Jeffrey.



PHARMACY WELCOMES NEW FACULTY MEMBERS

The School of Pharmacy is pleased to welcome two new faculty members who have accepted positions as Clinical Instructors in the Area Health Education Center Program.

JOHN S. WEINER has been working in the Fayetteville AHEC program since Oct. 13. He earned his B.S. in Biology in 1975 from Hobart and William Smith College in Geneva, New York and attended the University of Michigan where he was awarded his B.S. Pharmacy in 1980 and his Pharm.D. degree in 1982.

In FAHEC, some of his duties include working with the Family Practice Residency program, participating in rounds inservice education, drug utilization review, continuing education for area pharmacists, and precepting Academic Externship students.

In the future, Dr. Weiner hopes to add to his duties work with a major drug company in Phase III clinical trials of some of their psychotrophic drugs. Although this is "way down the road", Dr. Weiner says "I'm hoping that AHEC pharmacists in North Carolina may be able to coordinate the study in their various regions."

When not working hard to keep up with his new position, Dr. Weiner relaxes with tennis, camping, fishing, and snow skiing. He plans to keep the health science area in the family—his finance, Barbara Beattie is Medical Librarian at the Cape Fear Valley Hospital.

DENNIS M. WILLIAMS has been appointed the position of Associate Director of Pharmacy and Public Health Activities in the Eastern North Carolina AHEC region. In this new position, Dr. Williams will be responsible for designing and implementing multidisciplinary systems to support and to enhance the rationality of drug therapy in ambulatory care, and planning and coordinating educational programming. He will also be participating in the Pharmacy Academic Externship Program where he will teach and supervise students.

Dr. Williams graduated from the University of Kentucky in Louisville with a B.S. (1977) and Pharm.D. (1981) degrees in Pharmacy. He is a registered pharmacist and holds a professional licensure in Kentucky. He comes to us from a staff pharmacist position at the University of Kentucky Medical Center.

Dr. Dennis M. Williams

His primary interest is in patients with diseases including diabetes, hypertension, chronic lung disease, arthritis, and heart disease. His long term goal is in conducting research in patient care areas.

Although there is very little time for it, Dr. Williams' hobbies include volleyball and racquetball; unfortunately, he has to drive 20 miles to the nearest court.

POLYGRAPHS IN PHARMACY

by Deena Burge 3/5

The following article is the first in this year's series of papers selected for publication in Script for papers written by 3/5 students in Pharmacy 21, Drugs, the Pharmacist, and the Health Care System. Opinions expressed in the papers are by no means selected as an official stance of the School of Pharmacy.

Throughout history man has strived to discern truth from falsehood. As a consequence, a multitude of "tests" have been conceived to aid in this quest for truth. In earlier times a suspect might have been expected to lick a hot iron or spit chewed rice powder to prove his innocence or guilt. But with the advance of man's knowledge and technology, mechanical tests were developed which proved to be somewhat more scientific. The first of these, invented in 1895 by Italian criminologist Cesare Lombroso, was a device that measured slight changes in blood pressure and heart rate in suspected wrong-doers being questioned. Fifteen years later another Italian, Vittorio Benussi, claimed that detectable deviations in respiration were also related to the telling of untruths. Still later, a machine to record changes in arterial blood pressure was utilized by the United States in World War I while interrogating prisoners. By 1921 an instrument had been developed which combined all three physiological processes—blood pressure, heart rate, respiration—and recorded them simultaneously on one graph. This polygraph precursor was then refined by Leonard Keeler who went on to develop polygraph-interrogation techniques and who is largely responsible for the introduction of the polygraph into the area of business and industrial security.

CHAIN STORES

One industry in particular that has employed the polygraph is the National Association of Chain Drug Stores. The group uses the device in pre-employment and/or periodic screening of employees. Perry Drug Stores, Inc., for example, require annual polygraph tests for its one thousand employees, while the Jack Eckerd Corporation spent five hundred thousand dollars in 1980 alone on polygraph tests for employees in its eight hundred-unit chain. In light of these figures, one might wonder why chain drug stores place such importance in subjecting current and potential employees to this extreme measure. The answer is money. In 1976 chain drug stores claimed to have lost 315 million dollars from employee theft and in 1980 reported the loss nearer to 700 million dollars. In response, more and more chain drug stores are implementing the polygraph as a means of deterring this kind of pilferage. A survey by the National Association of Chain Drug Stores found that of the responding stores, 81% used the polygraph and of these, 61% reported a decrease in theft after initiation of the polygraph. 94% of the total stores responding felt that it was essential to continue use of the polygraph. In addition, to possibly discourage internal theft, employers may also use the polygraph to obtain information about their employees such as criminal backgrounds, health problems, drug or alcohol abuse. It may be noted here that of the stores surveyed above, 14% of their current or potential employees refused to submit to the polygraph test. However, such refusal may result in termination of employment or disqualification of the applicant.

ACCURACY

Such great emphasis placed on the polygraph by the chain drug store industry might lead to the assumption that the test has a high degree of accuracy. However, while the polygraph industry advocates 90% accuracy, studies show that their accuracy lies nearer to 70%. This inexactness may be attributed, for the most part, to the areas of response error and examiner error, both of which will create erroneous polygraph results. Response errors may include the nervousness one may have in reaction to the test itself, physiological problems such as high or low blood pressure or respiratory ailments, and "guilt complexes" involving other nonrelated events. Examiner errors include the attitude with which the questioner administers the test that may cause the subject to feel at ease or feel threatened and also include personal subjectivity which ranges from the particular questions asked to the interpretation of the graph. In addition to these problems, the polygraph may actually screen out

"honest" subjects while the "dishonest" go undetected, depending upon the ease with which a person can lie and the degree to which a person rationalizes illegal action.

The continued controversy over the use of polygraphs in industry have raised many questions about their legality, for instance, it seems their use may be in violation of our basic civil rights. In 1977 the American Pharmaceutical Association Committee on Public Affairs concluded that "polygraph testing is an invasion of privacy and violates the Fifth Amendment privilege against self-incrimination, the constitutional presumption of innocence until proven guilty, of the Sixth Amendment right to confront and cross-examine one's accusers, and of the Fourth Amendment protection against unreasonable searches." Nonetheless, a 1981 ruling by a three membered panel of the National Labor Relations Board upheld an administrative law judge's ruling that an employer can in fact subject his employees to a polygraph if the employer has used polygraph tests in the past, and if the employees know that submitting to a test could be a condition of continued employment. A point to be mentioned here is that although no federal decisions have been made on this issue, eleven states have enacted their own laws prohibiting the use of pre-employment polygraphs. These are Alaska, California, Connecticut, Delaware, Hawaii, Maryland, Massachusetts, New Jersey, Oregon, and Washington. Enforcement of the law in these states, however, is difficult since job applicants may not be aware of their rights and fail to report the violator.

The overall effect of polygraph use in pharmacy is an apparent undermining of the professional ideal. Professionals are deemed to be trustworthy, independent, and unsupervised to the degree their license allows. The polygraph and its implications deny the very meaning of the professional. As a result, severe morale and motivation problems are occurring among chain store employed pharmacists. The polygraph has also created an atmosphere of distrust between employee and employer and may indeed have caused an unfavorable image in the public eye as to the trustworthiness of their pharmacist. Still another negative effect of the polygraph is the precedence it seems to be taking over the state board exams in determining the fitness of a pharmacist to practice.

While it is understandable that chain drug stores are naturally concerned about profit margins, this concern can, and indeed has, gone too far. The proof is in the individual pharmacy career destroyed by an inaccurate mechanical device. Further proof lies in the damaged public image of the pharmacy profession from without and the demoralized pharmacists' view from within. Alternate methods of management techniques must be utilized. These may include taking more time to screen applicants in personal interviews, or implementing policies which are fair and promote job pride and involvement. Whatever the alternative, it is clear that the polygraph has no place among professionals.

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BIRTH

Gary and MARCIA Parks, Asheboro, are happy to announce the birth of their daughter, Jennifer Ann. Jennifer Ann was born on December 23rd and weighed 7 pounds 4 ounces. Grover and Ruby Creech of Smithfield are the proud grandparents.

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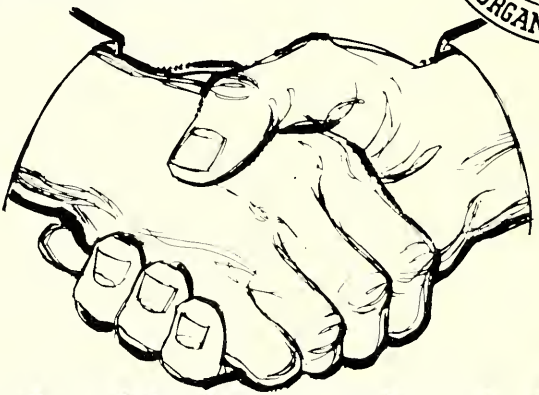

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PREMARKETING APPROVAL

The U. S. Supreme Court has recently heard oral arguments in the *Generix* case. In this action, a generic drug manufacturer in Florida challenged the FDA's right to require premarketing approval of generic drugs when the product's active ingredients had already been approved. The FDA required that the manufacturer show that its generic product contained not only the same active ingredients as an approved drug, but that it also produced an equivalent effect on the body as the approved drug. The government claimed that inactive ingredients can have a significant effect on a drug's action, and thus inactive ingredients must also go through premarketing approval. Without such preclearance, the government claimed that there was no way to determine that the generic copy was actually equivalent to the approved drug.

Attorneys for Generix contended that the Food, Drug & Cosmetic Act addresses only "active ingredients" and not "drug products." Attorneys asserted that Congress never intended the FDA to regulate every drug product, for this task would be impossible. The manufacturer's attorney also argued that the *Generix* case was moot because the FDA had seized the unapproved generic drugs manufactured by the company, and the company had no intention of shipping unapproved generic products in the future.

During the questioning before the Supreme Court, several of the justices indicated that if the government were to prevail in its claims, the FDA would have to require NDAs for over-the-counter drugs as well as for prescription drugs. This would then require premarketing approval for OTC products. There was, however, concern that if the Supreme Court did not uphold the FDA's interpretation of its "new drug" regulations, there would be no guarantees about the safety and efficacy of generic drugs and few health professionals would want to use such products. This could result in serious harm to the generic drug industry as well.

Pharmaceutical industry has taken notice of the FDA's vacillation on the issue of generic drugs. Approximately 4 years ago, the government took issue with the Pharmaceutical Manufacturers Association on the question of whether all generic products should be bioequivalent and bioavailable when compared to innovator products. Now, the government has assumed exactly that position. Justice Blackmun stated in the November 3rd hearings, "I take it that the government has not been consistent over these years." The FDA has previously been successful in the *Premo and Pharmadyne* cases, and the *Generic* case it argued quite strongly against the Eleventh Circuit ruling that "inactive" ingredients of drug products do not fall within the new drug provisions of the FD&C Act. It will be some time before a decision is handed down by the Supreme Court.

David Roucke

David Roueche, having completed a five-month training program ending with an intensive three-week seminar here, has been named a Syntex professional medical representative, according to Richard Casey, Syntex vice president of sales.

In this position, Roueche will provide health care professionals in the Salisbury, N. C. area with medical background and usage information on Syntex pharmaceutical products. Roueche will report to Roger Kinsey, Syntex district manager.

Prior to joining Syntex, Roueche was a child support enforcement agent for the Rowan County Department of Social Services. He received a B.A. in psychology from Pfeiffer College, Albemarle, N. C.

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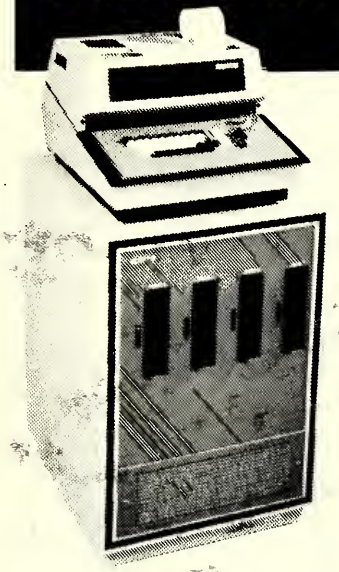

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